The Auditor-General
Audit Report No.12 2012–13
Performance Audit

Administration of Commonwealth Responsibilities under the National Partnership Agreement on Preventive Health

Australian National Preventive Health Agency

Department of Health and Ageing

Australian National Audit Office

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Australian National Audit Office

Canberra ACT
5 December 2012

Dear Mr President
Dear Madam Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Australian National Preventive Health Agency and the Department of Health and Ageing in accordance with the authority contained in the *Auditor-General Act 1997*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit, and the accompanying brochure, to the Parliament. The report is titled *Administration of Commonwealth Responsibilities under the National Partnership Agreement on Preventive Health*.

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

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Contents

Abbreviations

ABS	Australian Bureau of Statistics
Advertising Guidelines	*Guidelines on Information and Advertising Campaigns by Australian Government Departments and Agencies* (2010)
AIHW	Australian Institute of Health and Welfare
ANPHA	Australian National Preventive Health Agency
ANPHA Act	*Australian National Preventive Health Agency Act 2010*
CALD	Culturally and Linguistically Diverse
CEIs	Chief Executive Instructions
CEO	Chief Executive Officer
CGGs	*Commonwealth Grant Guidelines*
COAG	Council of Australian Governments
DoHA	Department of Health and Ageing
ERC	Expenditure Review Committee of Cabinet
Finance	Department of Finance and Deregulation
FMA Act	*Financial Management and Accountability Act 1997*
HWA	Health Workforce Australia
ICC	Independent Communications Committee
LGA	Local Government Area
NHMRC	National Health and Medical Research Council
PM&C	Department of the Prime Minister and Cabinet
SEIFA	Socio-Economic Indexes for Areas
SLA	Service Level Agreement
The Agreement	National Partnership Agreement on Preventive Health
The Collaboration	National Eating Disorders Collaboration

Summary and Recommendations

Summary

Introduction

1. Chronic diseases—illnesses that are prolonged in duration, do not often resolve spontaneously, and are rarely cured completely—are the leading causes of death and disability in Australia, and their prevalence is increasing in Australia and many parts of the world.[1] For these reasons, and to contain the high and growing cost of health care[2], preventing chronic diseases has been a major health priority of the Australian, state and territory governments in recent years.

2. To address the rising prevalence of lifestyle-related chronic diseases, the Australian Government has committed $932.7 million over nine years, commencing in 2009–10, to a new National Partnership Agreement on Preventive Health (the Agreement), agreed with state and territory governments through the Council of Australian Governments (COAG).[3] The Agreement sets out five high-level objectives, relating to:

- providing support to Australians in reducing their risk of chronic disease in various settings (including schools, workplaces and communities);
- working with industry sectors (including food, sport, recreation and fitness) to offer healthy food choices and increase physical activity;
- supporting behavioural change through public education and social marketing;
- investment in the evidence base and a national workplace audit; and
- the establishment of a new national preventive health agency.

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1 Australian Institute of Health and Welfare, *Risk factors contributing to chronic disease*, Canberra, 2012, p. 5.

2 While the cost of chronic disease in Australia is not known, the Australian Institute of Health and Welfare has reported that the cost of services for health conditions that involve chronic diseases was well over $13 billion in 2004–05. ibid., p. 10.

3 National Partnership Agreements are one of three different mechanisms for making payments to states and territories under the Federal Financial Framework agreed by COAG. The other two mechanisms are National Specific Purpose Payments, for spending in key service delivery sectors, and general revenue assistance, consisting of Goods and Services Tax payments and other general revenue assistance.

3. To achieve these objectives, the Agreement outlines the delivery of 11 initiatives or outputs, summarised at Table S1.

Table S1: Initiatives under the National Partnership Agreement on Preventive Health

Healthy children, up to $325.9 million from 2011–12 to 2017–18
Programs, delivered by state and territory governments, to increase levels of physical activity and the intake of fruit and vegetables of children from birth to 16 years of age in child care centres, pre-schools, schools and other settings.
Healthy workers, up to $294.3 million between 2011–12 and 2017–18
Workplace health programs, delivered by state and territory governments, that focus on decreasing rates of overweight and obesity, increasing levels of physical activity and intake of fruit and vegetables, ceasing smoking and reducing harmful levels of alcohol consumption. Up to $289.1 million is available to state and territory governments, and the remaining $5.2 million is being used by the Australian Government to develop supporting soft infrastructure, such as national standards and benchmarking and a National Healthy Workplace Charter.
Healthy communities, $71.8 million from 2009–10 to 2013–14
Community-based healthy lifestyle programs, which facilitate increased access to physical activity, healthy eating and healthy weight activities for disadvantaged groups and those predominantly not in the paid workforce.
Social marketing—$151.5 million from 2009–10 to 2015–16
• ***Measure Up*** **($48.5 million)**
Extend the duration of the *Measure Up* social marketing campaign by three years and expand its reach to high-risk groups. Activities under the campaign aim to raise awareness of healthy lifestyle choices and the link between lifestyle behaviours and the risk of some chronic diseases. The Australian Government is managing the national program of social marketing activity ($30.5 million) through the *Swap It, Don't Stop It* campaign under *Measure Up.*
• **National Tobacco Campaign ($103 million)**
National level social marketing activities focusing on ceasing smoking to promote healthy behaviours and address the rising prevalence of smoking related chronic diseases.
Industry partnership, $1 million from 2009–10 to 2012–13
Partnerships between the government and relevant industry sectors to encourage industry policies and practices that are consistent with the Australian Government's healthy living agenda.
Enabling infrastructure, $88.3 million from 2009–10 to 2015–16
• **Australian National Preventive Health Agency (ANPHA), including the Preventive Health Research Fund ($59.8 million)**
Establishment of ANPHA on 1 January 2011 to provide evidence-based advice on preventive health and manage national preventive health programs. The Preventive Health Research Fund, administered by ANPHA, provides funding of $13.1 million for preventive health research, and in particular translational research (that is, translating research into practice).

• **Expansion of the Australian Health Survey ($15 million)**
Expansion of the National Nutrition and Physical Activity Survey, now part of the Australian Health Survey, to include children aged two years and over, Indigenous Australians and bio-medical measures (that is, data from participants who voluntarily agree to provide blood and urine samples).
• **Enhanced state and territory surveillance ($10 million)**
State and territory governments will collect and report on the performance benchmarks agreed within the Agreement and implement surveillance systems using the nationally agreed framework for measurement.
• **National Eating Disorders Collaboration ($3 million)**
A collaboration of experts in the fields of research, education, health promotion, public health and mental health, as well as the media, to progress a coordinated national approach to address eating disorders and provide information to adolescents, schools, health providers and the media.
• **Workforce Audit and Strategy ($0.5 million)**
An audit to identify the workforce required to deliver the settings-based initiatives funded through the Healthy Workers, Healthy Children and Healthy Communities initiatives and options to ensure sufficient capacity within the sector to support the rollout of activities and programs. ANPHA is developing the preventive health workforce strategy.

Source: ANAO summary of information provided by the Department of Health and Ageing.

4. State and territory governments are responsible for implementing two initiatives under the Agreement—Healthy Children and Healthy Workers—and undertaking social marketing that complements Commonwealth activity as well as enhanced state and territory surveillance. The Department of Health and Ageing (DoHA), which is responsible for achieving the Australian Government's health priorities (outcomes), including reducing the incidence of preventable mortality and morbidity throughout Australia, and the Australian National Preventive Health Agency (ANPHA), which was established as part of the Agreement, are responsible for implementing the remaining initiatives in consultation with the states and territories.[4]

5. The Agreement was originally intended to be implemented over the period 2009 to 2015. However, in June 2012, the Agreement was varied and it is

[4] ANPHA was established under the *Australian National Preventive Health Agency Act 2010* and, under Section 2A(1) of the Act, advises on and manages national preventive health programs. At June 2012, ANPHA had 39 full-time equivalent staff and, in the revised Budget for the 2012–13 financial year, a total resourcing allocation of $69.4 million. ANPHA is a prescribed agency under *the Financial Management and Accountability Act 1997*.

now scheduled to conclude in 2018.[5] It provides for both 'facilitation' and 'reward' payments, totalling $643 million, to be made to states and territories. The facilitation payments are used to fund activities undertaken to implement Agreement-related reforms, while the reward payments reward jurisdictions for achieving agreed improvements in aspects of healthy living.[6] At the time of audit fieldwork to October 2012, none of the components relating to the reward payments had been assessed or made.

6. The reward payments will be assessed against a number of performance benchmarks that are specified in the Agreement and translate its medium to long term outcomes to the period of the Agreement. From 1 July 2009 to 30 June 2018, the Agreement aims to:

- prevent any rise in the level of obesity of both children and adults in the Australian community;
- lead to increases of 0.6 and 1.5 respectively in the mean number of daily serves of fruits and vegetables consumed by children and adults; and
- lead to increases in the proportion of children and adults participating in moderate physical activity every day of at least 60 minutes for children and 30 minutes for adults.

7. The Agreement also aims to lead to a 3.5 per cent reduction in the proportion of adults smoking daily by 2013, against a 2007 baseline.[7]

Audit objective and criteria

8. The audit objective was to assess the effectiveness of DoHA and ANPHA in fulfilling the Commonwealth's role in implementing the COAG National Partnership Agreement on Preventive Health, to achieve the

[5] The Australian Government varied the Agreement to extend its duration by three years in recognition of the difficulties inherent in achieving population change within the short time period of the original Agreement and difficulties being encountered in measuring the outcomes (described in the following paragraph) required to assess the performance of states and territories and their eligibility for reward payments.

[6] Originally, the reward payments under the Healthy Children and Healthy Workers initiatives for achievement of seven performance benchmarks equalled the facilitation payments for these initiatives (that is, they were 50 per cent of the total maximum payment to the state or territory). However, following the renegotiation of the agreement in June 2012, the reward payments were reduced and now amount to 25 per cent of the total maximum payments to states and territories for these initiatives. The facilitation payments were correspondingly increased and now amount to 75 per cent of total payments.

[7] See Part 4 of the Agreement—Performance benchmarks and indicators.

Agreement's objectives, outcomes and outputs, including supporting all Australians to reduce their risk of chronic disease. The high-level audit criteria used to make this assessment were that DoHA and ANPHA:

- were effectively fulfilling the Commonwealth's roles to plan for, contribute to and monitor the achievement of the Agreement's objectives, outcomes and outputs;
- have developed the enabling infrastructure to support initiatives for healthy living, including by effectively establishing ANPHA;
- were efficiently and effectively conducting social marketing campaigns; and
- were effectively implementing other initiatives under the Agreement.

Overall conclusion

9. To target the lifestyle risk factors of chronic disease, the Australian Government has committed $932.7 million to the National Partnership Agreement on Preventive Health (the Agreement). The Government, through the Department of Health and Ageing (DoHA) and the new Australian National Preventive Health Agency (ANPHA), is responsible for implementing the Agreement, in conjunction with the states and territories.[8] The Agreement is at a relatively early stage of implementation, having commenced in 2009–10, and is now scheduled to terminate in June 2018.

10. Overall, a good start has been made in implementing the Commonwealth's roles under the Agreement. Between them, DoHA and ANPHA have commenced all Australian Government initiatives under the Agreement, with some well underway. In particular, the agencies have: contributed to planning for the implementation of the Agreement; commissioned social marketing campaigns to encourage Australians to reduce the incidence of smoking and obesity; provided grants to organisations to deliver community-based healthy lifestyle programs; liaised with, and entered partnerships with, industry sectors to promote a healthy living agenda; and helped fund and arrange the expansion of the Australian Health Survey, the

[8] To date, 11 initiatives have been pursued to realise the objectives set out in the Agreement, three of which are the responsibility of state and territory governments.

initial results of which will progressively become available between October 2012 and June 2014.

11. ANPHA, itself a key element of the enabling infrastructure under the Agreement, was established on 1 January 2011 with effective support from DoHA. ANPHA has made good progress in meeting its legislative requirements and strategic goals. Particular achievements include the development of a knowledge hub, completion of an initial round of 13 research grants, undertaking the development of a framework for the evaluation of the Agreement and development of an interim research strategy. In the first 18 months of operations, ANPHA has also established the key elements of governance envisaged under the Commonwealth *Australian National Preventive Health Agency Act 2010 (*ANPHA Act) and the *Financial Management and Accountability Act 1997* (FMA Act), including its Advisory Council, expert committees and Audit Committee.

12. While a good start has been made in implementing the Australian Government initiatives specified in the Agreement to deliver the associated outputs, challenges remain in measuring performance against the outcomes and objectives specified in the Agreement. To provide a sound basis for measuring performance against the benchmark targets in the Agreement, against which reward payments will be assessed from June 2016, DoHA still has work to do with the states and territories to finalise: the baseline data for the benchmarks specified in the Agreement[9]; the detailed methodology for collecting performance data; and the division of responsibilities between the Commonwealth and the states and territories for collecting the data. This work is also central to allowing an assessment of the Agreement in meeting its outcomes. It is also important that DoHA, in conjunction with states and territories, actively monitor their performance in achieving the Agreement's objectives, and identify opportunities to improve performance and support Australians to reduce their risk of chronic disease.

13. COAG did not intend that ANPHA hold exclusive responsibility for preventive health, with significant functions continuing to be the responsibility of DoHA and state and territory health departments. Nonetheless, the

[9] The baseline data for the national performance benchmarks, as indicated in paragraphs 6 and 7, is specified in the Agreement as the last available data at June 2009—apart from the 2007 adult smoking benchmark.

Australian Government has made a substantial investment in establishing ANPHA as a standalone agency with national responsibilities, necessitating a clear allocation of roles and responsibilities between agencies so as to avoid unnecessary overlap and duplication. To minimise confusion about the respective roles of DoHA and ANPHA (and other health agencies) going forward, there would be benefit in DoHA and ANPHA actively reviewing the alignment of their responsibilities, particularly as ANPHA's role in preventive health continues to develop.

14. As an agency subject to the FMA Act, ANPHA is expected to observe the requirements of the Australian Government's campaign advertising framework and the 2010 *Guidelines on Information and Advertising Campaigns by Australian Government Departments and Agencies* (Advertising Guidelines). The audit assessed the effectiveness of ANPHA's administration in developing the second and third rounds of the *Swap It, Don't Stop It* advertising campaign and its adherence to the requirements of the advertising framework. While ANPHA adhered to the certification, publishing and reporting requirements of the Advertising Guidelines, there was scope to more clearly correlate the factual information with the messages being delivered in the campaigns by including, in compliance statements, a list of statements appearing in creative materials that is clearly linked to the references backing the claims.

15. The audit also assessed ANPHA's administration of the first round of grants under its Preventive Health Research Fund against the *Commonwealth Grant Guidelines* (CGGs). While the key processes adopted by ANPHA were generally consistent with the CGGs, ANPHA did not ensure that the Health Minister was contemporaneously briefed on her specific obligations as a funding approver under the FMA Act, *Financial Management and Accountability Regulations 1997* (FMA Regulations) and the CGGs. Further, the CEO of ANPHA approved a variation to the research grants funding that the Minister had originally approved. While the CEO had authority to approve the variation, it would have been prudent for ANPHA to advise the Minister at that time of the need for the variation and subsequent new approval, as the research grant guidelines informed applicants that the Minister would be the funding approver. Subsequent advice provided to the Minister to address these matters contained some minor errors, indicating that there is scope for ANPHA to improve quality control over its briefing material.

16. The facilitation payments that have been made to the states and territories to the end of June 2012 greatly exceed the $84.7 million that they had

budgeted to spend to that time in their implementation plans. This occurred as a result of the variation to the Agreement, which re-profiled the funding allocation resulting in an additional payment of $82.5 million to the states and territories. These additional funds were part of the facilitation payments initially scheduled to be paid in July 2012. As a consequence, the states and territories rather than the Commonwealth will receive the benefit of the early payment of those funds. In this regard, the ANAO has previously reported on the opportunity costs of making significant pre-payments and recommended that DoHA provide advice to the Health Minister on the risks, if any, and opportunity costs of making such payments in advance of need.[10]

17. The ANAO has made two recommendations relating to the implementation of the Agreement. One recommendation is directed at DoHA, to give priority to progressing the means for measuring performance against the benchmarks in the Agreement. The other recommendation is directed at ANPHA, to more clearly demonstrate the factual basis for statements appearing in campaign advertisements.

Key findings by chapter

Implementation framework for the National Partnership Agreement on Preventive Health (Chapter 2)

18. DoHA has established consultative and decision making forums to manage the implementation of Commonwealth, state and territory responsibilities under the Agreement. While these have worked reasonably well, state and territory health departments consulted in the course of the audit indicated that, as a means of strengthening national coordination arrangements, there would be benefit in reviewing the roles, responsibilities and operations of the two main management committees—the Implementation Working Group and the Healthies Steering Committee. These committees, which have Commonwealth, state and territory health department representation, were established to consider strategic and operational issues respectively. The Implementation Working Group did not meet between 2010 and 2012, and state and territory health departments consulted in the course of the audit saw benefit in the group continuing to meet to consider higher level strategic issues, with the focus of the Healthies Steering Committee being on

[10] ANAO Report No. 45 2011–12, *Administration of the Health and Hospitals Fund*, pp. 109–114.

operational matters. Reflecting these concerns, the Implementation Working Group agreed in September 2012 to a review of the terms of reference of the group and its sub-committees.

19. As indicated at paragraphs 6 and 7, the Agreement lists national performance benchmarks for reductions in health risk factors that the Commonwealth, state and territory governments agreed to meet over specified periods. The degree to which the benchmarks are met will determine the reward payments that are made to the states and territories under the Agreement.

20. While the Agreement clearly lists the national benchmarks, specification of the methods of collecting reliable and consistent data required to measure performance against the benchmarks has proved difficult. A broad framework for measuring performance benchmarks was approved by Health Ministers in November 2010, however the baseline data for the benchmarks have not yet been collated and how the data will be collected has still to be finalised.[11] These delays put at risk the consistent measurement of performance against the national benchmarks and the determination of reward payments to the states and territories. It is therefore important that DoHA places a high priority on finalising the baseline data and specifications and arrangements for collecting data to assess performance against the benchmarks.

21. Under the revised Agreement, the amounts of facilitation payments to the states and territories have been increased and the amounts of reward payments have been reduced commensurately. There have been large pre-payments of facilitation payments to the states and territories to the end of June 2012, including $82.5 million being paid by way of advance payments in June 2012, without advice to the Commonwealth Health Minister on the opportunity costs of the payments.

22. DoHA and ANPHA have actively engaged with a range of key stakeholders involved in implementing preventive health programs. DoHA has liaised closely with the food industry in the implementation of the Food and Health Dialogue under the Industry Partnership Agreement. Key

[11] The Chairman of the COAG Reform Council, Paul McClintock, AO, has referred to the need for adequate data to report progress against performance indicators and benchmarks, noting that 'all National Agreements have examples of performance indicators which have no data or have inadequate data to report progress'. Paul McClintock, AO, *The COAG Reform Agenda: How are governments performing so far*, CED, Melbourne, September 2010.

stakeholders also advised that ANPHA had actively engaged with their organisations since its establishment. While there was some delay against the original scheduling of ANPHA's planned publication of its Stakeholder Engagement Strategy, a final version was published in June 2012. ANPHA has also organised and participated in seminars and working groups with other agencies.

Australian National Preventive Health Agency (Chapter 3)

23. ANPHA has prepared a five-year strategic plan, and operational plans for 2011–12 and 2012–13, which have met requirements to be approved by the Minister for Health, after consultation with state and territory ministers for health. The first full performance report against the operational plan for ANPHA will be for the 2011–12 financial year. While ANPHA generally performed well against the 2011–12 operational plan, there was some slippage or adjustment to timelines and tasks, which is reflected in the 2012–13 operational plan.

24. ANPHA is required to meet governance and financial management arrangements under its enabling legislation (the ANPHA Act) and the FMA Act. ANPHA has established the key governance requirements required under the ANPHA Act and the FMA Act, including establishing the Advisory Council, expert committees and an Audit Committee, with a charter and work program covering risk management, fraud control and development of an internal audit plan. All committees have terms of reference and appointees to the committees have appropriate experience and qualifications.

25. ANPHA has established a risk management framework based on risk management standard AS/NZS/ISO 31000:2009. The Fraud Control Plan is generally in line with the Commonwealth Fraud Control Guidelines. While the risk management framework is generally sound, there would be benefit in ANPHA completing its business continuity and disaster recovery plans as soon as practicable. ANPHA should also satisfy itself that it has suitable risk mitigation strategies in place in relation to its outsourced services.

26. While ANPHA has prepared Chief Executive Instructions, the detailed rules and manuals which support them (with the exception of rules and manuals on procurements and grants) have not yet been completed. ANPHA has committed to completing the business rules by 31 December 2012. Once the necessary supporting financial rules and manuals for the Chief Executive Instructions have been completed, ANPHA will have established the key

elements of its governance and financial management framework, as envisaged under the ANPHA and FMA Acts.

Preventive health social marketing campaigns (Chapter 4)

27. The Australian Government, through DoHA, has a long history in running social marketing campaigns aimed at encouraging Australians to adopt healthy lifestyles and reduce the risk of contracting chronic diseases. The *Swap It, Don't Stop It* campaign, focusing on overweight and obesity prevention, and the National Tobacco Campaign, focusing on reducing smoking, are two campaigns that were originally developed by DoHA, but are now conducted by ANPHA. Phase 2 of the *Measure Up* obesity prevention/active lifestyle social marketing campaign and the National Tobacco Campaign transferred to ANPHA upon its establishment. The development and implementation of the two campaigns was undertaken by the department on behalf of ANPHA until December 2011. During this period of co-administration there was some initial confusion as to which agency had the primary responsibility for reporting expenditure against the campaign, as evidenced in the lack of procurement reporting for *Swap It, Don't Stop It* in DoHA's and ANPHA's Murray Motion (Senate Order 192)[12] reporting for 2010–11. ANPHA has since included the relevant *Swap It, Don't Stop It* contracts as part of its 2011–12 financial year Senate Order reporting.

28. The ANAO assessed the *Swap It, Don't Stop It* campaign's compliance with the Advertising Guidelines. Compliance assessments prepared for the Independent Communications Committee[13] for the second and third rounds of the campaign contained reasonable representations of compliance with the five Information and Advertising Campaign Principles in the Advertising Guidelines. The chief executive's certification was signed by the appropriate authority and uploaded to the Department of Finance and Deregulation's website in a timely way.

[12] The Senate Order for Departmental and Agency Contracts was introduced in 2001 to improve public access to information about Australian Government contracting. The main principle on which the Order is based is that parliamentary and public access to government contract information should not be prevented, or otherwise restricted, through the use of confidentiality provisions, unless there is sound reason to do so.

[13] The Independent Communications Committee was established in March 2010 to provide advice to agency Chief Executives on advertising campaigns with expenditure over $250 000, including advice on compliance with principles 1 to 4 of the Advertising Guidelines.

29. Principle 2 of the Advertising Guidelines provides that campaign materials should enable the recipients of the information to distinguish between facts, comment, opinion and analysis (paragraph 20) and, where information is presented as a fact, it should be accurate and verifiable (paragraph 21). The *Swap It, Don't Stop It* campaign provides 'suggestions' for better health. Nonetheless, these suggestions should be evidence-based. The Statement of Compliance did not contain an evidence matrix or other document outlining the factual basis for statements made in the *Swap It, Don't Stop It* creative materials. While the Advertising Guidelines do not specify the use of such a document, the inclusion in future compliance statements of a mechanism to clearly correlate the factual statements appearing in creative materials to the references backing the claims would strengthen the transparency of ANPHA's conduct of social marketing campaigns.

30. Principle 4 of the Advertising Guidelines provides that campaigns should be evaluated to determine their effectiveness (paragraph 33). There have been two evaluations using a selection of Australians within the intended audience and charting their recall, views and the effect of the *Swap It, Don't Stop It* advertisements. The results of evaluations of the *Swap It, Don't Stop It* campaign have been encouraging, and other indications of the effectiveness of these campaigns (and other related measures) will be provided once the results of the current National Health Survey are available from October 2012 and after completion of ensuing National Health Surveys, which are usually conducted every two years.

Preventive health research and other preventive health initiatives (Chapter 5)

31. ANPHA has made good progress in establishing national preventive health infrastructure, including through the administration of an initial round of 13 research grants and the development of an interim research strategy. However, it remains a priority for ANPHA to finalise and start implementing its final research strategy so that its objectives can be realised as soon as possible.

32. As mentioned in paragraph 15, there was evidence of imprecision in ANPHA advice to the Minister on financial framework issues and financial variations relating to the first round of research grants, indicating there is scope for improved quality control over material going to the Minister.

33. The ANAO's analysis of DoHA's administration of the Healthy Communities initiative, and administration of Local Government Area grants under that initiative, found that key processes were generally consistent with the CGGs. As the Local Government Area grants are at an early stage of implementation, it is too early to assess the benefits of the program for participants. However, early indications from an evaluation of the pilot sites in Phase 1 showed a general increase in participant awareness of health risk factors and the skills needed to address these risks.

34. One area where there is room for improvement in DoHA's administration of the Healthy Communities initiative is the Quality Framework. Notably, only a small number of applications have received service provider and program registration since the Healthy Living Network went live on 20 March 2012, although all six National Program Grants are now registered. DoHA has advised that it is now working closely with the external service provider and local government areas on the promotion of the Healthy Living Network and encouraging local government areas to register.

35. The implementation of the Australian Health Survey is proceeding within expected timeframes. The expected completion of the survey is in contrast to the implementation of the Preventive Health Workforce Audit and Strategy. While the audit was completed after difficulties in defining workforce boundaries were resolved, the finalisation of the Preventive Health Workforce Strategy is not expected to be presented to the COAG Standing Council on Health until the second half of 2013. To limit the risk that there will be only a limited opportunity to achieve significant outcomes before the Agreement term expires, ANPHA should consider placing a higher priority on the implementation of the Preventive Health Workforce Strategy.

Summary of agency responses

36. The two audited agencies provided the following summary responses, with each agency's full response included at Appendix 1.

Australian National Preventive Health Agency

> The ANAO's examination of the governance framework and the program implementation arrangements will contribute to the agency's compliance framework and continued sound governance.

Department of Health and Ageing

The Department agrees to Recommendation No. 1 and adds that processes are currently underway to address this through established governance arrangements under the Agreement. Consultation with relevant technical experts and with the states and territories, for resolving data issues to measure performance for reward payments as highlighted in this recommendation, are currently being progressed by the Department.

Recommendations

Set out below are the ANAO's recommendations and the agencies' responses.

Recommendation No.1

Para 2.21

To provide a sound basis for measuring performance against the benchmarks in the National Partnership Agreement on Preventive Health, against which reward payments will be assessed, the ANAO recommends that the Department of Health and Ageing gives a high priority to finalising:

(a) the baseline data for the benchmarks specified in the Agreement;

(b) the detailed methodology for collecting performance data; and

(c) Commonwealth, state and territory responsibilities for collection of the performance data.

DoHA response: Agreed.

Recommendation No.2

Para 4.19

To provide additional support to the agency's chief executive and the Independent Communications Committee, the ANAO recommends that the Australian National Preventive Health Agency includes in future compliance statements a document that clearly correlates the evidence for factual statements appearing in campaign creative materials with those campaign statements.

ANPHA response: Agreed.

Audit Findings

1. Introduction

This chapter provides background information on the National Partnership Agreement on Preventive Health and outlines the audit approach, including the audit objective, criteria and scope.

Background

1.1 Chronic diseases are the leading causes of death and disability in Australia and their prevalence is increasing in Australia and many parts of the world. For this reason, and because of a desire to contain the very high cost of health care, preventing chronic diseases has been a major health priority of the Australian, state and territory governments in recent years.[14] Table 1.1 provides a definition of chronic diseases.

Table 1.1

Definition of chronic diseases

Chronic diseases are illnesses that are prolonged in duration, do not often resolve spontaneously, and are rarely cured completely. Chronic diseases are complex and varied in terms of their nature, how they are caused and the extent of their effect on the community. While some chronic diseases may make large contributions to premature death, others contribute more to disability. Features common to most chronic diseases include: • complex causality, with multiple factors leading to their onset; • a long development period, for which there may be no symptoms; • a prolonged course of illness, perhaps leading to other health complications; and • associated functional impairment or disability.

Source: Australian Institute of Health and Welfare, *Risk factors contributing to chronic disease*, Canberra, 2012, p. 5.

1.2 The Australian Institute of Health and Welfare (AIHW) reported in 2012 on the prevalence in the Australian community of six risk factors of chronic disease.[15] It found, among other things, that 99 per cent of Australians

[14] While the cost of chronic disease in Australia is not known, the Australian Institute of Health and Welfare has reported that the cost of services for health conditions that involve chronic diseases was well over $13 billion in 2004–05. AIHW, *Risk factors contributing to chronic disease*, Canberra, 2012, pp. 5, 10.

[15] ibid. The AIHW defines risk factors as determinants of health that affect health negatively. The six risk factors examined were: daily smoking; physical inactivity; risky alcohol consumption (for long-term health); inadequate consumption of fruit and vegetables, and consumption of whole milk; obesity (described by both body mass index and waist circumference); and high blood pressure (also known as hypertension).

have at least one risk factor and most people have three, and that, as the number of risk factors increases, so too does the likelihood of having a chronic disease.[16] AIHW findings on other risk factors contributing to chronic disease are shown at Table 1.2.

Table 1.2

AIHW findings on the prevalence of chronic diseases in Australia

Fifteen per cent of people still smoke on a daily basis.
More than 60 per cent of males who drink at risky or very risky levels drink on all days of the week. Of women who drink at risky or very risky levels, 44 per cent report that they drink each day.
Almost 60 per cent of people do not undertake sufficient physical activity to confer a health benefit, and more than 80 per cent spend more than three hours each day sitting during their leisure time.
Around 60 per cent of people are either overweight or obese, and higher rates of obesity are found in those aged 55–64.
The proportion of people reporting high blood pressure increases with age, and is relatively uncommon in those aged under 45.
For many risk factors, rates are higher in those people who live in areas that are more socio-economically disadvantaged.
People who live in major cities have lower levels of risk factors than those who live in other areas of Australia, with the exception of insufficient fruit and vegetable consumption.

Note: The AIHW publication, *Risk factors contributing to chronic disease*, states that 18 per cent of people still smoke on a daily basis. However, AIHW's *2010 National Drug Strategy Household Survey Report* (Drug Statistics Series No. 25, July 2011), p. ix, states that smoking tobacco daily is now at 15.1 per cent, down from 16.6 per cent three years previously. This is the benchmark figure that is used in public statements on smoking.

Source: AIHW, *Risk factors contributing to chronic disease*, Canberra, 2012, p. 16.

1.3 The Department of Health and Ageing (DoHA) is responsible for achieving the Australian Government's health priorities (outcomes). This includes responsibility for population health (Outcome 1), which aims to reduce the incidence of preventable mortality and morbidity throughout Australia.[17]

[16] By way of illustration, the AIHW found that males with five or more risk factors are three times more likely to report chronic obstructive pulmonary disease than males with two or fewer risk factors and that females with five or more risk factors are three times more likely to report stroke, and two and a half times more likely to report depression than females with two or fewer risk factors. ibid., p. vii and p. 52.

[17] Mortality is the condition of being mortal, or susceptible to death. Morbidity denotes a condition causing poor health, such as injury or illness.

1.4 The Australian National Preventive Health Agency (ANPHA) within the Health and Ageing portfolio was established on 1 January 2011, under the *Australian National Preventive Health Agency Act 2010* (ANPHA Act). Under the ANPHA Act, ANPHA's functions are to advise on and manage national preventive health programs.[18] Its aim, as set out in the 2011–12 Health and Ageing Portfolio Budget Statements, is to:

> reduce the prevalence of preventable disease through research and evaluation to build the evidence base for further action, and by managing lifestyle education campaigns and developing partnerships with non-government sectors.[19]

1.5 The Australian Government committed to establish ANPHA as part of the National Partnership Agreement on Preventive Health, which is discussed below. As at June 2012, ANPHA had 39 full-time equivalent staff and, in the Budget for the 2012–13 financial year, its total resourcing allocation was $69.4 million.[20] Currently ANPHA and DoHA have responsibilities for administering certain components of the National Partnership Agreement on Preventive Health.

The National Partnership Agreement on Preventive Health

1.6 To target the lifestyle risk factors of chronic disease, the Australian Government has committed $932.7 million over nine years, commencing in 2009–10, to a new National Partnership Agreement on Preventive Health (the Agreement), agreed with state and territory governments through the Council of Australian Governments (COAG).[21] This Agreement was devised to fund 'programs that will improve health outcomes and reduce pressure on the health system in the long term' and build on action which was taken by

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18 *Australian National Preventive Health Agency Act 2010*, section 2A(1).

19 Australian Government, *Health and Ageing Portfolio Budget Statements 2011–12*, *Budget Related Paper No. 1.10*, p. 3.

20 Senate Community Affairs Legislation Committee, *Official Committee Hansard: Estimates*, 31 May 2012.

21 National Partnership Agreements are one of three different mechanisms for making payments to states and territories under the Federal Financial Framework agreed by COAG. The other two mechanisms are National Specific Purpose Payments, for spending in key service delivery sectors, and general revenue assistance, consisting of Goods and Services Tax payments and other general revenue assistance.

Commonwealth, state and territory governments in COAG's 2006 Australian Better Health Initiative.[22]

1.7 The Agreement sets out five high-level objectives, relating to:

- providing support to Australians in reducing their risk of chronic disease in various settings (including schools, workplaces and communities);
- working with industry sectors (including food, sport, recreation and fitness) to offer healthy food choices and increase physical activity;
- supporting behavioural change through public education and social marketing;
- investment in the evidence base and a national workplace audit; and
- the establishment of a new national preventive health agency.

1.8 The Agreement also aims to contribute to the following medium to long term outcomes:[23]

(a) increase the proportion of children and adults at health body weight by three percentage points within ten years;

(b) increase the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15 per cent within six years;

(c) reduce the proportion of Australian adults smoking daily to 10 per cent within ten years;

(d) reduce the harmful and hazardous consumption of alcohol; and

(e) help assure Australian children of a healthy start to life, including through promoting positive parenting and supportive communities, and with an emphasis on the new-born.[24]

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[22] The Australian Better Health Initiative was announced by COAG on 10 February 2006. The Commonwealth and state and territory governments agreed to provide $1.1 billion over five years to: establish a new approach to promotion, prevention and early intervention; provide better care for people in the community, including in rural and remote Australia; provide better care for older people in hospitals; and provide better care for younger people with disabilities in nursing homes.

[23] The translation of these outcomes to the period of the Agreement is articulated in the Agreement's performance benchmarks, which are shown in Table 2.1.

[24] COAG, *National Partnership Agreement on Preventive Health*, December 2008, Clause 3.

1.9 To achieve these objectives and outcomes, the Agreement outlines the delivery of 11 initiatives or outputs, as shown in Table 1.3.

Table 1.3

Initiatives under the National Partnership Agreement on Preventive Health

Healthy children, up to $325.9 million from 2011–12 to 2017–18
Payments to state and territory governments to deliver programs to increase levels of physical activity and the intake of fruit and vegetables of children from birth to 16 years of age in child care centres, pre-schools, schools and other settings.
Healthy workers, up to $294.3 million between 2011–12 and 2017–18
Workplace health programs that focus on decreasing rates of overweight and obesity, increasing levels of physical activity and intake of fruit and vegetables, ceasing smoking and reducing harmful levels of alcohol consumption. The $294.3 million comprises: • up to $289.1 million to state and territory governments to fund healthy living programs in workplaces; and • $5.2 million is being used by the Australian Government to develop soft infrastructure to support the implementation of state and territory programs from July 2011. This includes the development of national standards and benchmarking, a National Healthy Workplace Charter and national awards for best practice in workplace health programs.
Healthy communities, $71.8 million from 2009–10 to 2013–14
Community-based healthy lifestyle programs that facilitate increased access to physical activity, healthy eating and healthy weight activities for disadvantaged groups and those predominantly not in the paid workforce. Grants have been provided to 92 local government areas (LGAs) across Australia to deliver these programs and to six organisations to provide healthy lifestyle programs (such as exercise programs) for LGAs to incorporate into their local programs. A quality framework, which includes a registration body and information portal, assists LGA grant recipients, and other communities, to gain access to effective healthy lifestyle programs.
Social marketing—$151.5 million from 2009–10 to 2015–16
• ***Measure Up* ($48.5 million)**
Extending the duration of the *Measure Up* social marketing campaign by three years and expanding its reach to high-risk groups. Activities under the campaign aim to raise awareness of healthy lifestyle choices and the link between lifestyle behaviours and the risk of some chronic diseases. The Australian Government is managing the national program of social marketing activity ($30.5 million) through the *Swap It, Don't Stop It* campaign under *Measure Up*, while the states and territories are delivering activities at a local level to reinforce and extend the national campaign messages ($18.0 million).
• **National Tobacco Campaign ($103 million)**
National level social marketing activities focusing on ceasing smoking to promote healthy behaviours and address the rising prevalence of smoking related chronic diseases. The Commonwealth administers these funds, in consultation with the states and territories, which have committed to fund supporting local-level activities.

Industry partnership, $1 million from 2009–10 to 2012–13
In consultation with states and territories, develop and support partnerships between governments and relevant industry sectors to encourage changes in their policies and practices so they are consistent with the Australian Government's healthy living agenda.
Enabling infrastructure, $88.3 million from 2009–10 to 2015–16
• **Australian National Preventive Health Agency (ANPHA), including the Preventive Health Research Fund ($59.8 million)**
Commencing operation on 1 January 2011, ANPHA assists in progressing the prevention agenda by: • providing evidence-based advice to health ministers; • supporting the development of evidence and data on the state of preventive health in Australia and the effectiveness of preventive health interventions; • putting in place national guidelines and standards to guide preventive health activities; and • managing some initiatives under the Agreement and other preventive health activities. The Preventive Health Research Fund, administered by ANPHA, provides funding of $13.1 million for preventive health research, and in particular translational research (that is, translating research into practice).
• **Expansion of the Australian Health Survey ($15 million)**
Expansion of the National Nutrition and Physical Activity Survey, now part of the Australian Health Survey, to include children from two years and over, Indigenous Australians and bio-medical measures (that is, data from participants who voluntarily agree to provide blood and urine samples). Essential population health data will be collected on such things as dietary intake, nutritional status, physical activity levels and prevalence of chronic disease risk factors.
• **Enhanced state and territory surveillance ($10 million)**
This initiative provides funding for the implementation of a jurisdictional-based system of health, nutrition and physical activity monitoring surveys. The states and territories will collect and report on the agreed performance benchmarks within the Agreement and implement surveillance systems using the nationally agreed framework for measurement.
• **National Eating Disorders Collaboration ($3 million)**
Facilitate the implementation of a nationally consistent and comprehensive approach to promotion and prevention, early intervention and management of eating disorders. The collaboration brings together experts in the field of research, education, health promotion, public health and mental health, as well as the media, to progress a coordinated national approach to eating disorders and provide information to adolescents, schools, health providers and the media. The Australian Government administers the funds for this initiative.
• **Workforce Audit and Strategy ($0.5 million)**
This initiative provided funding for an audit, which has identified the workforce required to deliver the settings-based initiatives funded through the Healthy Workers, Healthy Children and Healthy Communities initiatives and options to ensure sufficient capacity within the sector to support the rollout of activities and programs. ANPHA is, in part, using the outcomes of the audit in preparing a strategy for development of the preventive health workforce.

Source: ANAO summary of DoHA information.

1.10 Under the Agreement:

- the Australian Government is responsible for developing the soft infrastructure to support workplace-based programs for healthy living, managing the rollout of community-based programs, developing partnerships with relevant industry sectors, establishing ANPHA and supporting its roles around social marketing, surveillance, research, and the workforce audit and strategy; and
- state and territory governments are responsible for delivering programs to children and workplace-based programs to encourage healthy lifestyles, local level social marketing activities that support national level healthy living activities, services that complement and support national level tobacco campaigns, and the expansion of local level surveillance capacity.[25]

1.11 The Agreement was originally intended to be implemented over the period 2009 to 2015. However, in June 2012, the Agreement was varied and it is now scheduled to conclude in 2018. The Australian Government revised the Agreement to extend its duration by three years in recognition of the difficulties inherent in achieving population change within the short time period of the original Agreement and difficulties being encountered in measuring the outcomes required to assess the performance of states and territories and their eligibility for reward payments.

1.12 The Agreement provides for both 'facilitation' and 'reward' payments to be made to states and territories. The facilitation payments are used to fund activities undertaken to implement Agreement-related reforms, while the reward payments reward jurisdictions that achieve agreed improvements in aspects of healthy living.

1.13 Reward payments under the Healthy Children and Healthy Workers initiatives are eligible to be paid to the states and territories for achievement of seven agreed performance benchmarks. Originally, the reward payments equalled the facilitation payments for these initiatives (that is, they were 50 per cent of the total maximum payment to the state or territory). However, following the renegotiation of the agreement in June 2012, the reward payments were reduced and now amount to 25 per cent of the unchanged total

[25] COAG, *National Partnership Agreement on Preventive Health*, December 2008, clauses 13 and 14.

maximum payments to states and territories for these initiatives (as indicated in Table 1.4). The facilitation payments were correspondingly increased and now amount to 75 per cent of total payments. At the time of audit fieldwork to October 2012, none of the components relating to the reward payments had been assessed or made.

Table 1.4

Structure of facilitation and reward payments to states and territories

Program	Initiative	Facilitation payments		Reward payments		Total revised payments
		Original $ million	Revised $ million	Original $ million	Revised $ million	$ million
Healthy Children	State and territory programs	162.8	244.4	162.8	81.5	325.9
Healthy Workers	State and territory workplace programs	144.7	216.8	144.7	72.3	289.1
Social Marketing	Local level initiatives for the *Measure Up* campaign	18.0	18.0	-	-	18.0
Enabling Infrastructure: Enhanced state and territory surveillance	State and territory computer aided telephone interviews	10.0	10.0	-	-	10.0
TOTALS		**335.5**	**489.2**	**307.5**	**153.8**	**643.0**

Note: Payments to the states and territories are rounded and there may therefore be some differences in totals. While $643 million is being provided under the Agreement, additional funds totalling $1.76 million are being provided outside the scope of the Agreement to assist Tasmania, the Northern Territory and the Australian Capital Territory in providing enhanced state and territory surveillance. This means that the total amount of Agreement-related expenditure is $644.7 million (after rounding of all payments).

Source: COAG, *National Partnership Agreement on Preventive Health*, December 2008, p. 9 and variation to the Agreement in June 2012, Clause 18.

Previous ANAO audits

1.14 There have been no previous performance audits that have dealt specifically with preventive health. However, preventive health forms part of

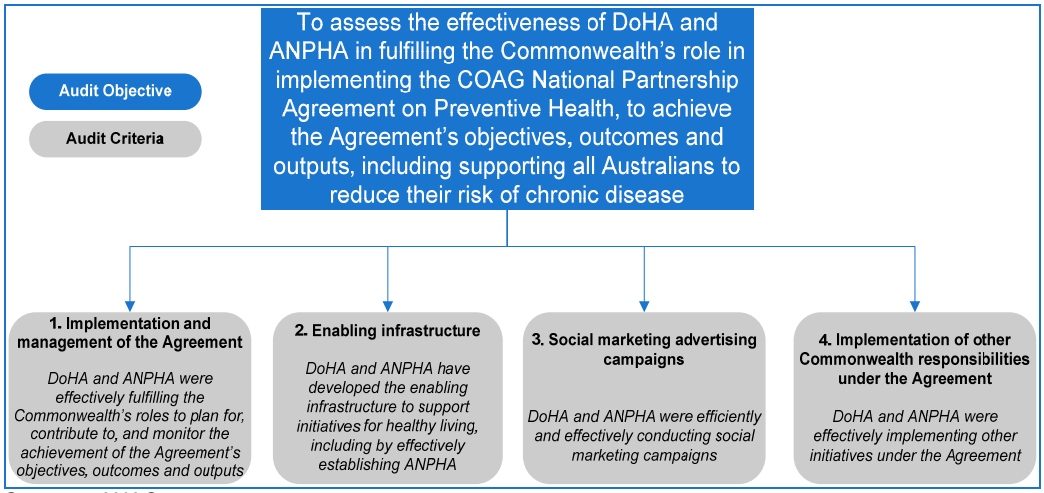
other health provision and an audit of the administration of primary care funding agreements recommended, among other things, that DoHA clarify performance expectations and reporting obligations.[26] The ANAO has also reported on the administration of Australian Government advertising. The approach used in the most recent audit on this topic was used to assess ANPHA's administration of social marketing campaigns on overweight and obesity prevention.[27]

Audit objective, criteria, scope and methodology

1.15 The audit objective and criteria are shown in Figure 1.1.

Figure 1.1

Audit objective and criteria



Source: ANAO.

1.16 To form an opinion against the audit objective, the audit team:

- examined a wide range of documentation and other preventive health related papers prepared by DoHA and ANPHA, including ministerial submissions, operational policies, program guidelines, departmental advice, program reviews and evaluations;
- interviewed key personnel at DoHA and ANPHA;

[26] ANAO, Audit Report No.41 2005–06, *Administration of Primary Care Funding Agreements*.

[27] The most recent performance audit report on this topic was: ANAO, Audit Report No.24 2011–12, *Administration of Government Advertising Arrangements: March 2010 to August 2011*.

- consulted key stakeholders, such as state and territory government personnel, industry representatives and members of voluntary sector organisations; and
- assessed the adequacy of DoHA and ANPHA systems in delivering services, such as grants to local government areas or for research into preventive health, and progress under the Agreement to July 2012.

1.17 The audit was conducted in accordance with the ANAO's auditing standards, at a cost to the ANAO of approximately $300 000.

Structure of the audit report

1.18 The audit findings are reported in four chapters, which examine key elements of DoHA's and ANPHA's administration of the Commonwealth's responsibilities under the Agreement, as outlined in Table 1.5.

Table 1.5

Structure of the report

2 Implementation Framework for the National Partnership Agreement on Preventive Health	Assesses the effectiveness of DoHA's management of the framework for implementing the Agreement and the level of stakeholder engagement by the department and ANPHA in implementing the Australian Government's responsibilities under the Agreement.
3 Australian National Preventive Health Agency	Assesses the role of ANPHA in preventing chronic disease and the effectiveness of the arrangements that have been put in place to manage the agency.
4 Preventive Health Social Marketing Campaigns	Assesses ANPHA's management of social marketing campaigns funded through the Agreement, including the processes used to certify that the campaigns were undertaken in accordance with the Australian Government's Campaign Advertising Guidelines.
5 Preventive Health Research and Other Preventive Health Initiatives	Assesses the effectiveness of ANPHA's strategies for facilitating research into health promotion and preventive health, including through a competitive grants program, and the implementation of other initiatives under the Agreement.

Source: ANAO.

2. Implementation Framework for the National Partnership Agreement on Preventive Health

This chapter assesses the effectiveness of DoHA's management of the framework for implementing the Agreement and the level of stakeholder engagement by the department and ANPHA in implementing the Australian Government's responsibilities under the Agreement.

2.1 Under the Agreement, the Australian Government, through DoHA, was responsible for implementing key initiatives—such as the establishment of ANPHA—and putting in place key elements of the governance, performance and stakeholder engagement frameworks agreed by COAG.

2.2 To assess the effectiveness of DoHA's management of the implementation framework for the Agreement, in accordance with its responsibilities set out in the Agreement, the ANAO examined:

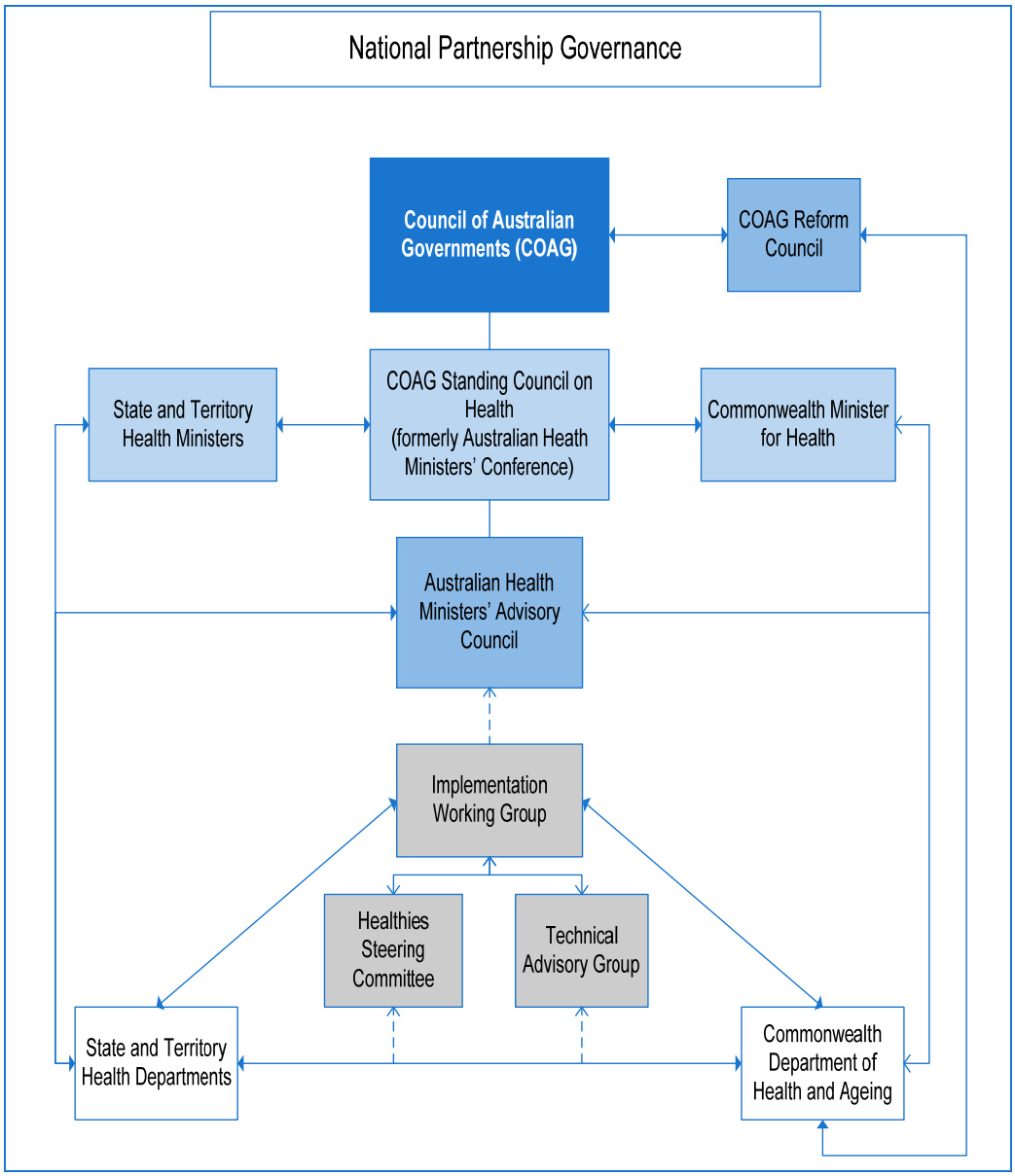
- the establishment and operation of new inter-governmental committees on preventive health;
- performance monitoring and reporting mechanisms;
- payments to the states and territories; and
- stakeholder engagement arrangements.

Inter-governmental committees on preventive health

2.3 The governance arrangements that were established for the Agreement are summarised in Figure 2.1.

Figure 2.1

Governance arrangements for the National Partnership Agreement on Preventive Health



Source: ANAO adaptation of diagram in National Partnership Agreement on Preventive Health Implementation Working Group, *National Partnership Agreement on Preventive Health—National Implementation Plan 2009–2015*, June 2009.

2.4 Of particular importance is the COAG Reform Council, a non-statutory body established by COAG to assist it in driving 'its reform agenda by

strengthening public accountability of governments through independent and evidence-based assessment and performance reporting'.[28] Under the Agreement, and consistent with Schedule C of the overarching *Intergovernmental Agreement on Federal Financial Relations*, the Australian Government will not make any reward payments to state and territory governments until the COAG Reform Council makes an independent assessment that performance benchmarks have been achieved.[29] The initial assessment is now expected to take place in 2016.

2.5 Commonwealth, state and territory ministers are represented on the Standing Council on Health and are responsible for agreeing the implementation arrangements for the Agreement.[30] To support this role, the Standing Council on Health receives advice from the Australian Health Ministers' Advisory Council, which comprises the heads of Commonwealth, state and territory health departments.

2.6 In addition to these high-level governance arrangements common to national health agreements, new inter-governmental committees were established on preventive health. In particular, an Implementation Working Group was established in 2009 to provide advice to the Australian Health Ministers' Advisory Council on the implementation arrangements to manage and oversee the development of implementation plans for all elements of the Agreement. This Working Group is chaired by the Australian Government and comprises deputy chief executive officers from all jurisdictions with responsibility for preventive health. The Working Group developed a National Implementation Plan for the Agreement, which was endorsed by the then Australian Health Ministers' Conference out-of-session in April 2010. The Working Group met on three occasions in 2009 and 2010.[31] It was convened again in May 2012 to discuss proposed changes to the Agreement, including extension of the period of the Agreement to 2017–18. While the Working Group's initial focus was on development of the implementation plan for the

[28] COAG Reform Council's mission statement.

[29] COAG, *National Partnership Agreement on Preventive Health*, December 2008, p. 4 and Schedule C of the Intergovernmental Agreement on Federal Financial Relations.

[30] The Standing Council on Health was formerly known as the Australian Health Ministers' Conference. The New Zealand Minister for Health and the Commonwealth Minister for Veterans' Affairs are also members of the Standing Council on Health.

[31] Although the Working Group did not meet in 2011, it was not disbanded and the Technical Advisory Group to the Working Group did meet.

Agreement, it has become a forum for higher level consideration of national partnership issues, such as reward payment methodology.

2.7 States and territories that were consulted in the course of the audit indicated that the absence of Implementation Working Group meetings between 2010 and 2012 meant that there was insufficient high-level direction of the implementation of the Agreement over this time and there was not a readily available forum for escalation of issues requiring high-level officer consideration. However, DoHA has advised that the Implementation Working Group did not meet between 2010 and 2012 because there were minimal issues that needed to be progressed by the group and that it has no record of state or territory representatives requesting that issues be addressed by the group over this time.

2.8 Ongoing coordination of the operation of the Agreement between the Australian Government and state and territory governments is undertaken by the Healthies Steering Committee, while the Technical Advisory Group is a non decision-making sub-committee of the Implementation Working Group that informs the development of data criteria and specifications and provides recommendations to the Implementation Working Group.

2.9 The Healthies Steering Committee comprises health agency representatives from all jurisdictions and first met in 2009. The committee meets three to four times a year. Progress on each of the initiatives in the Agreement and the experience of each of the jurisdictions in the implementation of their programs are discussed at Healthies Steering Committee meetings.

2.10 DoHA advised that it considers the Healthies Steering Committee to be an effective forum for information sharing on the Agreement with states and territories. It noted in this regard that the duration of Healthies Steering Committee meetings had been extended, at the request of states and territories, to provide a greater opportunity for sharing of experiences. However, states and territories that were consulted during the course of the audit indicated that they considered that some matters considered at Healthies Steering Committee meetings should more appropriately have been considered at Implementation Working Group meetings. This was because they involved higher-level decisions and not operational issues, which the Implementation Working Group was better tasked to manage, and were beyond the operational remit of the Healthies Steering Committee. Reflecting these concerns, the

Implementation Working Group agreed in September 2012 to review the operation of the group and its sub-committees.

Performance monitoring and reporting

2.11 In a speech in September 2010, the Chairman of the COAG Reform Council, Paul McClintock, AO, referred to the need for each National Partnership Agreement to have 'a strong conceptual framework underpinning it, providing a clear basis for linking the performance indicators with the desired objectives and outcomes'.[32] He also stressed the need for adequate data to report progress against performance indicators and benchmarks, noting that 'all National Agreements have examples of performance indicators which have no data or have inadequate data to report progress'.

Performance benchmarks and indicators

2.12 The Agreement identifies preventive health outcomes (as discussed in paragraph 1.8) agreed to by the Commonwealth, state and territory governments. It also lists performance benchmarks and associated timeframes for their achievement (Clause 15) against these outcomes, which will be used to determine reward payments to states and territories.[33] These performance benchmarks are listed in Table 2.1.

2.13 States and territories will receive partial payment for partial attainment of performance targets, with payments proportionate to achievement. For example, a jurisdiction will receive 50 per cent of the reward payment for a move half way to the target'.[34]

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[32] Paul McClintock, AO, *The COAG Reform Agenda: How are governments performing so far*, CED, Melbourne, September 2010.

[33] ANPHA has separate performance requirements and arrangements and these are examined in Chapter 3.

[34] National Partnership Agreement on Preventive Health Implementation Working Group, *National Partnership Agreement on Preventive Health—National Implementation Plan 2009–2015*, June 2009, p. 10.

Table 2.1

Performance benchmarks and indicators to determine reward payments to the states and territories

Benchmark / indicator	Change from baseline for each state as at:[(A)]		
Original Agreement (and revised agreement for daily smoking)	**2011**	**2013**	**2015**
Revised Agreement		**2016**	**2018**
Overweight and obesity			
Increase in proportion of children at unhealthy weight		5%	0%
Increase in proportion of adults at unhealthy weight		5%	0%
Healthy eating			
Increase in mean number of daily serves of fruits and vegetables consumed by children		0.2 serves for fruits 0.5 serves for vegetables	0.6 serves for fruits 1.5 serves for vegetables
Increase in mean number of daily serves of fruits and vegetables consumed by adults		0.2 serves for fruits 0.5 serves for vegetables	0.6 serves for fruits 1.5 serves for vegetables
Physical activity			
Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline		5%	15%
Increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week		5%	15%
Daily smoking			
Reduction in state baseline for proportion of adults smoking daily commensurate with following reductions from the 2007 national baseline	2%	3.5%	

Note: (A) Except for daily smoking, where the baseline data is for 2007, baselines are the last available data for June 2009. The 2016 benchmarks are to be assessed at June 2016 and the 2018 benchmarks at December 2017 (extrapolated to June 2018).

Source: COAG, *National Partnership Agreement on Preventive Health*, Clause 15, and variation to that Agreement in June 2012.

2.14 DoHA advised that the benchmarks were drawn from the Australian Dietary Guidelines and the Physical Activity Guidelines.[35] The baseline for the benchmarks is specified in the Agreement as the last available data at June 2009 (apart from the 2007 adult smoking benchmark). A *Framework for Measuring Performance Benchmarks* was developed to implement a methodology on how and what data should be collected to assess performance against the benchmarks. Finding an agreed and methodologically sound approach to determine how data would be gathered and measured proved difficult and led to a significant delay in finalising the performance framework.[36] It was planned to be finalised by September 2009 but was only approved by Health Ministers, through the then Australian Health Ministers' Conference, on 12 November 2010. National surveys were not considered feasible to meet the requirements of the benchmark measurements, and so the framework envisages that a formal national approach to telephone-based surveillance, using the computer-assisted telephone interview approach, would be developed.

2.15 Under the Enhanced State and Territory Surveillance Initiative, funding of $10 million is available to the states and territories 'to collect and report on agreed performance indicators and implement surveillance systems using [a] nationally agreed methodology'.[37] An additional $1.76 million has been provided to assist Tasmania, the Northern Territory and the Australian Capital Territory in implementing the initiative.[38] The states and territories have

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[35] These guidelines are available on the website of the National Health and Medical Research Council and DoHA. The Australian Dietary Guidelines (2003) are available at <http://www.nhmrc.gov.au/guidelines/publications/n29-n30-n31-n32-n33-n34>. [accessed 24 July 2012]. The Physical Activity Guidelines (2005) are at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-phys-act-guidelines#guidelines_adults> [accessed 24 July 2012].

[36] The delay in finalising the framework centred on several technical and statistical challenges, including:

- determining the minimum sample sizes for each jurisdiction to feasibly measure the required change with a reasonable level of precision;
- ensuring national consistency around all the questions used in the measurements; and
- the development of a set of questions to measure children's physical activity.

See National Health Information Standards and Statistics Committee, *National Partnership Agreement on Preventive Health: Framework for Measuring Performance Benchmarks*, August 2010, p. 2.

[37] DoHA, *National Partnership Agreement on Preventive Health: Implementation Overview*, June 2009, p. 8. States and territories had been paid $7.5 million of the $10 million to the end of June 2012. The remaining $2.5 million will be paid in 2012–13.

[38] It was agreed to provide additional funding to these jurisdictions as pro rata funding was considered to have been insufficient for these small jurisdictions to implement the initiative.

responsibility for the management of funds under the initiative, with the Australian Government providing guidance and a facilitation role to assist them in developing their capability. However, state and territory health departments consulted in the course of the audit indicated that there are likely to be considerable difficulties in achieving consistent data across all jurisdictions and that much more work needs to be undertaken to reach a satisfactory outcome.

2.16 DoHA has advised that the Productivity Commission and the COAG Reform Council will be consulted about the performance data required under the Agreement, and about the development of data specifications and data quality statements for reporting against the performance benchmarks.

2.17 Work on finalising data specifications for reporting against the performance benchmarks, including reporting by states and territories through the Enhanced State and Territory Surveillance initiative, was put on hold because of the revision to the Agreement in June 2012. The baseline data, data specifications and how the data will be collected have still to be finalised. DoHA has advised that, now that the June 2012 variation to the Agreement is in place, work is progressing to finalise the data specifications and baseline data.

2.18 The delay in specifying how benchmark measures data will be collected and responsibilities for their collection makes it difficult to derive accurate baseline data and hence to assess performance against the data. While recognising that there are challenges in obtaining comparable data across all jurisdictions, DoHA has work to do with the states and territories to finalise: the baseline data for the benchmarks specified in the Agreement; the detailed methodology for collecting performance data; and the division of responsibilities between the Commonwealth and the states and territories for collecting the data. This work is also central to allowing an assessment of the Agreement in meeting its outcomes.

2.19 In revising the Agreement, DoHA advised the state and territory governments that the Australian Government recognised that achieving the population level benchmarks in the timeframe of the Agreement, and so enabling state and territory governments to access the reward payments, would be difficult. The department stated that:

> the Commonwealth has listened [to feedback from the states and territories] regarding some of the difficulties inherent in achieving population level change within a short time period and the related issues around measuring

> tangible outcomes and subsequently, accessing reward payments. Taking these concerns into consideration, the Commonwealth is proposing to extend the NPAPH [National Partnership Agreement on Preventive Health] by three years to enable states and territories to demonstrate actual population level change in line with the performance benchmarks, and therefore increase the likelihood of reward funds being attained.[39]

2.20 Reports on performance against the benchmarks for Healthy Children and Healthy Workers were originally required to be provided against the benchmarks in Table 2.1, as at 30 June 2013 and 31 December 2014. With the extension of the term of the Agreement, reports as at 30 June 2016 and 31 December 2017 are now required.[40] The ANAO suggests that there would be benefit in monitoring progress against the benchmarks in the Agreement to enable any required remedial action to be taken by states and territories before then.

Recommendation No.1

2.21 To provide a sound basis for measuring performance against the benchmarks in the National Partnership Agreement on Preventive Health, against which reward payments will be assessed, the ANAO recommends that the Department of Health and Ageing gives a high priority to finalising:

(a) the baseline data for the benchmarks specified in the Agreement;

(b) the detailed methodology for collecting performance data; and

(c) Commonwealth, state and territory responsibilities for collection of the performance data.

DoHA response

2.22 Agreed.

[39] DoHA, Correspondence from the Chair of the Implementation Working Group to representatives from State and Territory Health Departments, 11 May 2012.

[40] Clause 19 of the revised National Partnership Agreement on Preventive Health. Of the funds available for reward payments (25 per cent of total payments for each of Healthy Children and Healthy Workers), 50 per cent will be paid for achievement of benchmarks at June 2016 and 50 per cent for achievement of benchmarks at December.

Implementation plans

2.23 The Agreement requires the parties to the Agreement to prepare an implementation plan to achieve the objectives of the Agreement. This plan is to be reviewed on an annual basis.[41]

2.24 The national implementation plan was completed in June 2009, six months after signature of the Agreement, and was approved out-of-session by Australian Health Ministers in October 2009.[42] Implementation plans for individual initiatives were also prepared and attached to the national implementation plan.

2.25 DoHA has advised that, as at May 2012, the national implementation plan had not been reviewed because there had not been extensive changes to the Agreement. However, with the extension of the Agreement to 2017–18, the national implementation overview will be updated by 31 December 2012 to reflect revised milestones.

2.26 An important component in monitoring the performance of National Partnership Agreements is the development and use of state and territory implementation plans. State and territory implementation plans are intended 'to provide additional detail as to how an individual jurisdiction intends to achieve the outcomes specified in [an] overarching National Partnership Agreement'.[43] Each state and territory has prepared implementation plans for the Healthy Children, Healthy Workers and social marketing initiatives activities in their state or territory.[44] With the renegotiation of the Agreement and its extension to 2017–18, the state and territory implementation plans are

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41 Clause 21 of the National Partnership Agreement on Preventive Health. A state or territory can request a change to the implementation plan at any time to accommodate emerging issues. These changes must be agreed with the Commonwealth and other parties.

42 National Partnership Agreement on Preventive Health Implementation Working Group, *National Partnership Agreement on Preventive Health—National Implementation Plan 2009–2015*, June 2009. A copy of the plan is available publicly on the Federal Financial Relations website, <http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health/preventative_health/all_states.pdf> [accessed on 13 June 2012]. One health minister responded in April 2010, and not in October 2009.

43 Department of the Treasury, *Developing Implementation Plans for National Partnership Agreements*, Federal Finances Circular No. 2011/04, December 2011, p. 1.

44 Under social marketing initiatives, states and territories are providing activities to support the *Measure Up* campaign. Copies of the state and territory implementation plans are available on the Federal Financial Relations website,<http://www.federalfinancialrelations.gov.au/content/npa/health_preventive.aspx> [accessed 19 November 2012].

to be revised by 31 December 2012 and, after approval by the Minister for Health, will be published on the Federal Financial Relations website.

2.27 The current state and territory implementation plans differ greatly in the level of detail they include. DoHA intends to work with the states and territories to simplify and standardise the implementation plans.

Soft infrastructure

2.28 Under the Agreement, the Australian Government committed to develop soft infrastructure to support the state and territory government Healthy Workers initiative efforts in reaching Australian employer groups from July 2011. This included the development of national standards and benchmarking, a National Healthy Workplace Charter and national awards for best practice in workplace health programs.

2.29 The Australian Government has progressed all elements of the soft infrastructure to support the Healthy Workers initiative, including the development of a national portal and toolkit for employers, collating all relevant jurisdictional material to a single web site.

2.30 In relation to the National Healthy Workplace Charter, the *Joint Statement of Commitment: Promoting Good Health at Work* was launched in August 2011. It lists core principles for a healthy workplace.

2.31 Section 11(1)(j) of the ANPHA Act states that one of the functions of ANPHA is to manage schemes that provide awards to participants to recognise excellent performance in matters relating to preventive health. For this reason, ANPHA has assumed responsibility for managing implementation of the Healthy Workplace Employer Awards. Since taking responsibility for this initiative in September 2011 (when the department sought the then Minister's agreement to transfer the funding and management of the awards to ANPHA), ANPHA has explored the option of integrating the awards into Safe Work Australia's existing award structures (this option was not accepted by Safe Work Australia) and has undertaken consultation with states and territories to understand how the awards could complement their existing and planned healthy workplace programs implemented under the Agreement.

Monitoring performance

2.32 Following the 2012 revisions to the Agreement, the states and territories are required to provide:

- annual progress reports against key milestones in states' and territories' implementation plans by 31st August each year for the previous financial year; and
- six-monthly reports on expenditure incurred to date and on key milestones in state and territory implementation plans due to be met in the coming six months, together with advice on any associated joint announcement opportunities.[45]

2.33 As mentioned previously, states and territories are also required to provide reports against the benchmarks specified in the Agreement as at 30 June 2016 and 31 December 2017 (extrapolated to June 2018) to be used by the COAG Reform Council to determine reward payments to states and territories.

2.34 The national implementation plan provides that, as part of quality assurance arrangements, there should be:

- regular (quarterly) progress reporting to the Implementation Working Group, including updates on progress towards achieving milestones and monitoring of financial expenditure; and
- regular reporting to the Minister for Health.[46]

2.35 The first annual reports by states and territories on progress against the implementation plans were for 2011–12, and DoHA's review of these reports had not been completed at the time of the audit fieldwork to October 2012.

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[45] The original Agreement only required reporting from the states and territories on performance against benchmarks and milestones on an annual basis, and states and territories were not required to report on financial expenditure (except that each state treasurer was required to provide a report to the Ministerial Council for Federal Financial Relations within six months of the end of each financial year). However, following revision of the Agreement in June 2012, six-monthly reports on progress and financial expenditure are now required so that the Commonwealth can obtain a 'clear outline of states and territory progress against implementation plans and provide early advice on any financial issues that may impact on state or territory progress'.

[46] National Partnership Agreement on Preventive Health Implementation Working Group, *National Partnership Agreement on Preventive Health—National Implementation Plan 2009–2015*, June 2009, pp.12 and 27.

2.36 Federal Finances Circular No. 2009/03 states that the:

> COAG Reform Council will be responsible for performance monitoring and reporting on National Partnerships to the extent that they support the objectives in National Agreements. The COAG Reform Council will also be the independent assessor of whether pre-determined performance benchmarks have been met before an incentive payment under a National Partnership is made.[47]

2.37 Quarterly performance reports are provided to the Standing Council on Health and the Australian Health Ministers' Advisory Council as part of the COAG Health Implementation Reporting Framework, which monitors the implementation of all national health reform measures**.** The framework was endorsed by the Australian Health Ministers' Advisory Council in July 2009 and is designed to advise Health Ministers of progress against agreed deliverables and to identify where implementation is not tracking as planned and where remedial action may be needed.[48] These reports are not provided to the COAG Reform Council and, in practice, the extent of performance monitoring by the COAG Reform Council, as distinct from its planned assessments against the pre-determined benchmarks in 2016 and 2018, is an examination of brief annual reports on the implementation of the initiatives.

Payments to the states and territories

2.38 As noted at Table 1.4, up to $643 million is being paid to states and territories under the Agreement and an additional amount of $1.76 million was provided to Tasmania, the Northern Territory and the Australian Capital Territory to supplement the Enhanced State and Territory Surveillance initiative. Details of the distribution of these funds over the term of the Agreement are shown at Table 2.2.

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47 Department of the Treasury, *Accountabilities under the new Federal Financial Framework*, Federal Finances Circular No. 2009/03, 3 April 2009, p. 6. This is also stipulated in Clause 31 of the Agreement.

48 COAG Health Implementation Reporting Framework, *Report to the Australian Health Ministers' Conference for the Period April to 16 September 2011*, p. 3. At a meeting of the Implementation Working Group in November 2009, agreement was reached that quarterly traffic-light reports, which identify the performance of the implementation for each initiative, would be provided to the Implementation Working Group. However, as the Implementation Working Group did not meet between April 2010 and May 2012, reliance was placed on progress reports to the Healthies Committee.

Table 2.2

Payments to states and territories under the revised National Partnership Agreement on Preventive Health

Year		State or territory NSW	Vic	Qld	WA	SA	Tas	NT	ACT	TOTAL
Facilitation payments										
2010-11		3.59	2.73	2.20	1.11	0.83	0.26	0.11	0.18	**11.00**
2011-12	**Initial facilitation**	24.11	18.18	15.23	7.77	5.41	1.72	0.84	1.25	**74.51**
	Additional facilitation	26.64	20.07	16.91	8.61	5.94	1.93	0.98	1.39	**82.47**
2012-13		17.36	13.07	10.91	5.57	3.91	1.22	0.57	0.89	**53.50**
2013-14		17.33	13.02	10.97	5.58	3.86	1.24	0.62	0.89	**53.51**
2014-15		17.33	13.02	10.97	5.58	3.86	1.24	0.62	0.89	**53.51**
2015-16		17.33	13.02	10.97	5.58	3.86	1.24	0.62	0.89	**53.51**
2016-17		17.33	13.02	10.97	5.58	3.86	1.24	0.62	0.89	**53.51**
2017-18		17.36	13.04	10.99	5.59	3.87	1.24	0.62	0.90	**53.61**
Total facilitation payments		**158.38**	**119.18**	**100.12**	**50.98**	**35.38**	**11.34**	**5.59**	**8.17**	**489.14**
Reward payments										
2016-17		24.89	18.72	15.76	8.03	5.55	1.78	0.88	1.29	**76.90**
2017-18		24.89	18.72	15.76	8.03	5.55	1.78	0.88	1.29	**76.90**
Total reward		**49.78**	**37.43**	**31.52**	**16.06**	**11.10**	**3.56**	**1.77**	**2.57**	**153.80**
Total facilitation and reward payments		**208.16**	**156.61**	**131.64**	**67.04**	**46.48**	**14.90**	**7.36**	**10.75**	**642.94**
Additional surveillance payments										
2011-12		-	-	-	-	-	**0.52**	**0.65**	**0.59**	**1.76**
Total additional surveillance		-	-	-	-	-	**0.52**	**0.65**	**0.59**	**1.76**

Note: Differences in totals are due to rounding of payments to states and territories.

Source: DoHA advice and documentation.

2.39 The facilitation payments that have been made to the states and territories to the end of June 2012 greatly exceed the amounts that states and territories had budgeted to spend to that time. Before the Agreement was revised, $85.5 million was paid to the states and territories, compared with $84.7 million they had budgeted in their implementation plans. After the variation to the Agreement, a further $82.5 million was paid by way of advance payments. In consequence the states and territories, rather than the Commonwealth, will receive the benefit deriving from those funds. In this regard, ANAO has previously reported on the opportunity costs of making

significant pre-payments and recommended that DoHA provide advice to the Health Minister on the risks, if any, and opportunity costs of making payments to funding recipients in advance of need.[49]

Stakeholder engagement

2.40 In recognising the cross-jurisdictional nature of the Agreement, close liaison and good communication with the states and territories and key stakeholder groups is important for its effective implementation. As such, both DoHA and the ANPHA have a need to engage effectively with stakeholders.

DoHA

Engagement with state and territory jurisdictions

2.41 As mentioned above, DoHA has established consultative and decision-making committees to promote close cooperation and engagement with other jurisdictions in the implementation of the Agreement. While these arrangements have generally been effective, as noted at paragraph 2.10, there is scope to improve the operation of these committees and their terms of reference of the Implementation Working Group and its sub-committees are now being reviewed.

Engagement with industry—the Industry Partnership initiative

2.42 A key activity mechanism that requires DoHA to engage with industry stakeholders is the Industry Partnership Initiative. Commencing in 2009–10, this initiative provides $1.0 million over four years to:

> develop and support partnerships between governments and various relevant industry sectors to encourage changes in their policies and practices so they are consistent with the Government's healthy living agenda.[50]

2.43 The key components of the Industry Partnership Initiative, planned for implementation by DoHA, are identified in Table 2.3.

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[49] ANAO Report No. 45 2011–12, *Administration of the Health and Hospitals Fund*, pp. 109–114.

[50] COAG, *National Partnership Agreement on Preventive Health*, December 2008, available at <www.health.gov.au/internet/main/publishing.nsf/Content/phd-prevention-np#children> [accessed 13 July 2012].

Table 2.3

Key components of the Industry Partnership Initiative

Description of component
• Development of principles for industry engagement on healthy eating and drinking (aligned with the Australian Dietary Guidelines). • Establishment of a comprehensive database containing nutrient profile data on a large range of products from the food manufacturing, retail and service sectors and associated purchasing/sales data to provide an indication of consumption patterns and food and nutrient intakes.(A) • Facilitation of information sharing between different sectors of the food and beverage industry, different sectors of the government, health non-governmental organisations and research bodies involved in food innovation through a DoHA coordinated and funded conference. • Promotion of consistent industry and government consumer messaging on healthy eating practices through the development of a strategy that supports public awareness of healthy eating in line with the Australian Dietary Guidelines (governed by the principles described above). • Development of an engagement strategy with the fitness and weight loss industries based on year two and three achievements under the Healthy Communities component of the Agreement.

Note: (A) DoHA is currently conducting a pilot of a nutrient database, called HARVEST, which is designed to have a suitable interface between the food industry's database and that of Food Standards Australia New Zealand. However, in May 2012, DoHA advised that the implementation of HARVEST would only take place if the department was satisfied with the reliability of input nutrient data provided by manufacturers on the labelling of their products.

Source: National Partnership Agreement on Preventive Health Implementation Working Group, *National Partnership Agreement on Preventive Health—National Implementation Plan 2009–2015*, June 2009, pp. 52–53.

2.44 The national implementation plan for the Industry Partnership Initiative specified that DoHA's initial focus would be on the food and beverage industry and that it was designed to 'facilitate collaborative, voluntary engagement between government, industry and health non-governmental organisations'.[51] DoHA also specified that the initiative would build on the work undertaken by the Australian Government outside traditional regulatory controls. In this context, the Government engages with the food industry through a number of different voluntary forums to improve the nutritional profile of foods.[52]

[51] National Partnership Agreement on Preventive Health Implementation Working Group, *National Partnership Agreement on Preventive Health—National Implementation Plan 2009–2015*, June 2009, p. 51.

[52] An example is the Trans Fats Collaboration, established in 2006, to monitor and, where appropriate, reduce the level of trans fatty acids in food through voluntary industry action.

Footnote continued on the next page…

2.45 DoHA has largely completed many of the components identified in the national implementation plan, although there has been slippage in the completion of some planned activities. Of the five activities listed in Table 2.3, DoHA has completed the development of principles for industry engagement and the facilitation of information sharing between sectors (such as conducting three food innovation workshops).[53]

Australian National Preventive Health Agency

2.46 While ANPHA has responsibility for stakeholder consultation on preventive health matters under the Agreement[54], its enabling legislation also specifies that it is 'to encourage initiatives relating to preventive health matters through partnerships with industry, non-governmental organisations and the community sector'.[55]

2.47 ANPHA's *Strategic Plan 2011–2015* and *Operational Plan 2011–12* both detail a planned stakeholder engagement approach. For example, the *Strategic Plan 2011–2015* identifies that ANPHA has a strategic goal under Healthy Public Policy to:

> Promote and guide the development, application, integration and review of public, organisational and community-based prevention and health promotion policies.[56]

2.48 ANPHA's priority to August 2012 was on strategic and operational planning around how best to liaise with preventive health stakeholders, including participating in stakeholder activities. In this regard, ANPHA met most of its performance targets for its planned approach to stakeholder

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Engagement with the food industry currently occurs through the Health and Food Dialogue, which was established in early 2009, outside the Agreement, to provide a collaborative, non-regulatory platform for industry action on evidence-based food and health issues through activities such as food reformulation. ANAO consultation with the Food and Grocery Council indicates that this dialogue has been constructive.

53 Areas where there has been partial progress in the implementation of planned outcomes relate to: the completion of a nutrient profile database (where a pilot database is being developed); the promotion of consistent industry and government consumer messaging on healthy eating practices; and the development of an engagement strategy with the fitness and weight loss sectors (which has not taken place).

54 COAG, *National Partnership Agreement of Preventive Health*, December 2008, p. 7.

55 *Australian National Preventive Health Agency Act 2010*, s. 11(1)(h).

56 ANPHA, *Strategic Plan 2011–2015*, p. 15.

engagement, albeit with some slippage from its planned completion dates for finalising key documents.

2.49 ANPHA's operational plan for 2011–12 identified that it would develop a stakeholder engagement strategy with the aim of setting out 'how ANPHA will engage with others to inform action and advice, build strategic partnerships and to support disease prevention and health promotion efforts throughout the Australian community'.[57] ANPHA had planned to release a draft stakeholder engagement strategy for public comment by November 2011 and the final strategy in March 2012. However, the draft strategy was released for public comment in February 2012 and the strategy was finalised (after further public consultation on the draft) in June 2012.

2.50 Other key activities that ANPHA planned to undertake in 2011–12 were the development of:

- an industry engagement strategy and principles and procedures to guide all industry engagement; and
- a strategy to guide the work of Medicare Locals in effective health prevention and health promotion activity.[58]

2.51 The industry engagement strategy forms part of ANPHA's stakeholder engagement strategy. Many stakeholders advised the ANAO that they had been consulted on the draft strategy and one stakeholder commented on the need for engagement with industry on the consumption of food and health risks associated with obesity to be clearly distinguished from engagement with industry on tobacco use and alcohol consumption, both of which it believed required different engagement strategies.[59]

2.52 To guide the work of Medicare Locals in effective health prevention and health promotion activity, in June 2012 ANPHA and the Australian Medicare Local Alliance jointly released:

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[57] ANPHA, *ANPHA Stakeholder Engagement Strategy Consultation*, 6 July 2012. <http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/stakeholder-engagement-strategy> [accessed 1 October 2012].

[58] ANPHA, *Operational Plan 2011–12*, p. 9.

[59] While the final engagement strategy identifies ANPHA's planned engagement approach, it also clearly indicates the different attitude to be taken with the tobacco industry in relation to reducing rates of cigarette smoking.

- a monograph of evidence for preventive health and health promotion through primary health care;
- a framework for prevention and health promotion for Medicare Locals; and
- a resource toolkit for prevention and health promotion for Medicare Locals.[60]

2.53 ANPHA and the Australian Medicare Local Alliance consider that this will form a sound basis for cooperation in future years.

2.54 In 2012 ANPHA also organised and participated in a range of stakeholder activities, such as arranging seminars and participating in working groups with other agencies.[61]

2.55 Overall, interviews conducted by the ANAO with key ANPHA stakeholders indicate that they were supportive of the way that ANPHA has undertaken engagement activities since its establishment.

[60] ANPHA, *ANPHA Commits to Supporting Disease Prevention and Health Promotion in Medicare Locals*, 7 June 2012. <www.anpha.gov.au/internet/anpha/publishing.nsf/Content/anphamediarelease-07062012> [accessed 20 June 2012].

[61] ANPHA, *Details of Planned Stakeholder Activities in the Next Six Months*, May 2012.

3. Australian National Preventive Health Agency

This chapter assesses the role of ANPHA in preventing chronic disease and the effectiveness of the arrangements that have been put in place to manage the agency.

Introduction

3.1 The Explanatory Memorandum for the Australian National Preventive Health Agency Bill 2010 states that the Bill put forward to establish ANPHA would:

> support the Australian Health Ministers' Conference (Ministerial Conference), and through the Ministerial Conference, the Council of Australian Governments (COAG) in addressing the increasingly complex challenges associated with preventing chronic disease. This will include supporting these councils in their efforts to work across portfolios, jurisdictions and sectors in support of nationally agreed health policies.[62]

3.2 Since coming into existence on 1 January 2011, ANPHA's primary focus has been on: its establishment and strategic direction, including governance arrangements; the development and implementation of evidence-based approaches to preventive health initiatives targeting obesity, harmful alcohol consumption and tobacco; the conduct of social marketing related to these priority health risk areas; and the administration of a research program, including a research grants program.

3.3 This chapter assesses the effectiveness of ANPHA's:

- establishment to meet its governance and operational requirements and perform its preventive health functions;
- organisational arrangements;
- planning and reporting;
- risk management; and
- financial management arrangements.

[62] Australian National Preventive Health Agency Bill 2010—Explanatory Memorandum, p. 1.

Establishing ANPHA

ANPHA's key governance and operational requirements

3.4 The ANPHA Act sets out many of the key governance and operational requirements for the agency. ANPHA is also an agency under the *Financial Management and Accountability Act 1997* (FMA Act). The FMA Act specifies the financial controls for government agencies, including the collection and custody of public money and the management of appropriations and payments.

3.5 Table 3.1 summarises the key legislative arrangements for ANPHA in the ANPHA Act and the FMA Act.

Table 3.1

ANPHA's key legislative governance and operational arrangements

Australian National Preventive Health Agency Act 2010
Functions of ANPHA—specifies five agency functions relating to preventive health (listed in Table 3.2).
Chief Executive Officer (CEO) functions, appointment, terms and conditions—identifies the responsibilities of the CEO and arrangements for the employment of the CEO.
Employment arrangements for staff and consultants—details the employment arrangements for staff and consultants. Staff are to be employed under the *Public Service Act 1999*.
Advisory Council—the ANPHA Act defines the establishment, functions and powers of the council.
Establish committees—the CEO may establish committees to assist with his or her functions or to assist the Advisory Council in the performance of its functions.
Produce strategic and annual operational plans—the CEO must develop, have approved and take into account when exercising his or her functions a strategic and operational plan.
Delegation of powers—the CEO may delegate certain powers under the ANPHA Act.
Annual report—the CEO must prepare and present to the Minister an annual report for presentation in Parliament.
Special account—specifies the financial arrangements for ANPHA and its special account.
Grants—permits ANPHA to provide grants to a state, territory or person for preventive health. The terms of such assistance are to be set out in a written agreement between the parties.

Financial Management and Accountability Act 1997
Audit Committee—the CEO is required to establish and maintain an Audit Committee.
Fraud Control Plan—the CEO must implement a fraud control plan for ANPHA.
Developing and implementing Chief Executive Instructions—the CEO is authorised to give instructions to ANPHA officials on any matter necessary or convenient for carrying out or giving effect to the FMA Act or the *Financial Management and Accountability Regulations 1997 (*FMA Regulations).
Delegation of powers—the CEO may delegate certain powers under the FMA Act.
Inform minister—keeping the responsible Minister and the Finance Minister informed.
Resource use—promoting the proper use of Commonwealth resources.
Financial management—recovery of debts, keeping accounts and records and preparing audited annual financial statements.

Source: ANAO analysis of the ANPHA Act, FMA Act and related FMA Regulations.

3.6 These governance and financial management arrangements are examined in this chapter.

ANPHA's preventive health functions and responsibilities

3.7 ANPHA was established under the ANPHA Act 'to advise on and manage national preventive health programs'.[63] The ANPHA Act provides that the functions of the agency are to be interpreted in accordance with five 'objects', as listed in Table 3.2. In effect the objects of the ANPHA Act establish the scope of ANPHA's responsibilities. However, the Revised Explanatory Memorandum on the Australian National Preventive Health Agency Bill 2010 stated that these are not intended to be an exhaustive list of relevant objects.[64]

[63] *Australian National Preventive Health Agency Act 2010*, section 2A(1).

[64] Australian National Preventive Health Agency Bill 2010—Explanatory Memorandum, p. 4.

Table 3.2

The scope of ANPHA's responsibilities

Objects of the ANPHA Act[(A)]
Effectively monitor, evaluate and build evidence in relation to preventive health strategies.
Facilitate national health prevention research infrastructure.
Generate new partnerships for workplace, community and school interventions.
Assist in the development of the health prevention workforce.
Coordinate and implement a national approach to social marketing for preventive health programs.

Note: (A) The CEO of ANPHA also has specific functions at section 11 of the ANPHA Act.

Source: *Australian National Preventive Health Agency Act 2010*, section 2A(2).

3.8 The establishment of a preventive health agency was recommended in 2009 by the National Health and Hospitals Reform Commission and by the National Preventative Health Taskforce. These bodies considered that ANPHA should play a major role in promoting and influencing better health outcomes in Australia. For example, the National Health and Hospitals Reform Commission stated that the new agency:

> should have a broad strategic and tactical role in order to drive a fundamental paradigm shift in how we as Australians, and our health system, think and act about health…Our model is fundamentally about engaging the whole community in prevention—individuals, the health sector, business, public health, researchers, sports, arts, the media, the finance sector, as well as governments.[65]

3.9 The National Preventative Health Taskforce also stated that ANPHA should be:

> a national leader for prevention in Australia. It must be capable of driving the prevention agenda across many sectors and within a diverse range of stakeholders through collaborative partnerships, coordination of activity at the national, state and local levels, and the provision of strategic advice to inform government policy.[66]

[65] National Health and Hospitals Reform Commission, *A Healthier Future for All Australians*, Canberra, June 2009, p. 97.

[66] National Preventative Health Taskforce, *National Preventative Health Strategy—the roadmap for action*, Canberra, 30 June 2009, p. 69.

3.10 The establishment of ANPHA was considered to provide the opportunity for a stronger cross-jurisdictional approach to health prevention, inclusive of non-government organisations and industry. As the Minister for Health and Ageing stated in the second reading speech on the ANPHA Bill:

> In the past the prevention effort has been neglected. We know that arrangements have been fragmented and lacked cohesion and focus ...
>
> A new approach is needed. And the new Australian National Preventive Health Agency will play a key role in achieving this ambition through the deployment of a skilled and dedicated team which can work flexibly and responsibly.[67]

3.11 To enhance public perceptions of its role, ANPHA obtained the approval of the Parliamentary Secretary to the Prime Minister to use separate branding to describe itself.[68]

3.12 Feedback received by the ANAO from stakeholders indicates that ANPHA has made a good start in implementing its responsibilities. Importantly, ANPHA has been working closely with DoHA and other agencies in the Health portfolio to develop partnerships that recognise these agencies' areas of expertise, and drawing on that expertise.[69] This can also be expected to promote consistency between the agencies in their approaches to preventive health. Nonetheless, some stakeholders considered that there is fragmentation and lack of clear delineation of responsibility for preventive health between DoHA and ANPHA, in particular. By way of illustration, while ANPHA has responsibility for the National Tobacco Campaign, DoHA still funds elements of the campaign that focus on specific target groups, including Indigenous Australians. Similarly, responsibility for overweight and obesity prevention is shared between DoHA and ANPHA.[70]

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67 The Hon Nicola Roxon MP, Hansard, House of Representatives, 29 September 2010, pp. 77 to 80.

68 ANPHA staff now use the term 'Promoting a Healthy Australia' as part of its branding in its dealings with the public.

69 Agencies in the Health portfolio with which ANPHA has worked closely include the Australian Institute of Health and Welfare, the National Health and Medical Research Council and Health Workforce Australia. ANPHA is now developing Memoranda of Understanding with some of these agencies, enabling it to access these agencies' expertise on an ongoing basis, and so avoiding the need to develop an independent and competing capability.

70 DoHA engages with the food industry through the Industry Partnership Initiative (such as the Food and Health Dialogue), while ANPHA also has other key responsibilities in overweight and obesity prevention, such as the *Measure Up* social marketing campaign.

3.13 The ANAO recognises that some degree of overlap in the role of DoHA and ANPHA (and other Health portfolio agencies) is likely in the early stages of ANPHA's operations. It would also have been difficult for ANPHA to assume full responsibility for preventive health functions until it had developed the capacity to do so (and DoHA has provided valuable support to ANPHA since its establishment). Further, it was not intended that ANPHA hold exclusive responsibility for preventive health, with significant functions continuing to be the responsibility of DoHA and state and territory health departments. However, to minimise confusion about the roles of DoHA and ANPHA (and other agencies) in the longer term, there would be benefit in DoHA and ANPHA monitoring the alignment of their various roles and responsibilities, particularly as ANPHA continues to develop its role in preventive health. The Australian Government has made a substantial investment in establishing ANPHA as a standalone agency, necessitating a clear allocation of roles and responsibilities so as to avoid unnecessary overlap and duplication into the future.

ANPHA budget

3.14 Under the Agreement, $17.6 million (and $13.08 million for the Research Fund) was made available to ANPHA for the three years from 2010–11 to 2012–13. ANPHA has also been tasked with administering the *Measure Up* (*Swap It, Don't Stop It*) overweight and obesity prevention campaign, the National Tobacco Campaign, and the National Binge Drinking Strategy expansion measures.[71] While the binge drinking measures are not part of the Agreement, they are directly related to reducing the risks of chronic diseases in the Australian community.

3.15 In 2011–12, ANPHA advised that its total administered expenditure on the social marketing campaigns and its research and national binge drinking grants programs amounted to $31.7 million. Around $22 million related to the social marketing campaigns, which are considered in Chapter 4.

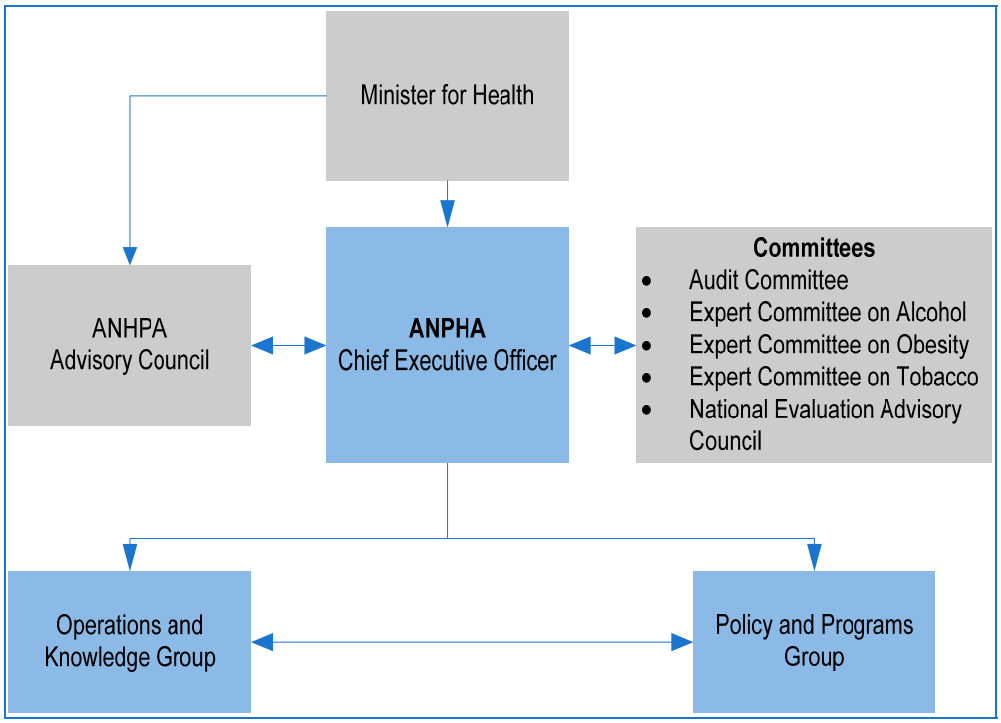
[71] Funding of $50 million over four years to 2013–14 was provided for the National Binge Drinking Strategy expansion measures.

Organisational arrangements

3.16 ANPHA's organisational structure is shown at Figure 3.1.

Figure 3.1

ANPHA's organisational structure



Source: ANPHA.

3.17 As noted in Table 3.1, ANPHA's staff are employed under the *Public Service Act 1999*. As at the end of June 2012, ANPHA had a staffing complement of 39 full-time equivalent officers.

Chief Executive Officer's accountabilities

3.18 The CEO of ANPHA[72] is accountable to the Minister for Health for the compliance and performance of ANPHA, including with respect to financial

[72] The current ANPHA CEO took up her appointment in September 2011. Prior to her appointment, there were two acting CEOs.

management, risk management, fraud control and general management. The CEO also reports to the COAG Standing Council on Health, via the Minister for Health, on the agency's performance against agreed five-year strategic and annual operational plans.[73]

ANPHA committees

3.19 ANPHA has established the Advisory Council and Audit Committee, which are required under the ANPHA Act and the FMA Act respectively. It has also established a number of expert committees.

Advisory Council

3.20 The Advisory Council is established under the ANPHA Act with a function to provide advice and make recommendations to the CEO either on its own initiative or at the request of the CEO.[74] The Advisory Council cannot issue directions to the CEO, as the CEO retains all legislative responsibility for ANPHA's administration.

3.21 The ANPHA Act allows the CEO to determine matters in the relation to the operation of the Advisory Council. The Acting CEO authorised the Advisory Council Member Guidelines in August 2011.[75]

3.22 The Advisory Council held its first meeting in July 2011. It is required by the ANPHA Act to meet at least four times a year but also as necessary. The ANAO's examination of Advisory Council meeting minutes indicates that this requirement was met for the 2011–12 financial year, the first year of ANPHA's operations.

3.23 The agenda and minutes of Advisory Council meetings indicate that the council has routinely considered potential conflict of interest issues. It has considered and discussed a number of topics in relation to preventive health, including ANPHA's initial areas of focus for preventive health, which target

[73] The Minister for Health is also required to consult with the Standing Council on Health about the appointment of the CEO: ANPHA Act, Section 14.

[74] The ANPHA Act specifies that the membership of the Advisory Council must consist of one member representing the Commonwealth, at least one member, but not more than two, representing the governments of the states and territories, and at least five but not more than eight other members with expertise relating to preventive health. There are currently 11 members of the Advisory Council.

[75] *Australian National Preventive Health Agency—Advisory Council Member Guidelines*, July 2011 (approved by the Advisory Council on 28 July 2011 and authorised by the CEO on 2 August 2011).

harmful alcohol consumption, tobacco use and obesity. In this regard, it has provided support and advice in accordance with the ANPHA Act.

3.24 The ANAO *Better Practice Guide on Public Sector Governance* suggests that, despite their advisory nature, boards such as the ANPHA Advisory Council can add value if they are involved actively and regularly in the functions of strategic planning and risk management.[76] The Advisory Council has provided advice on ANPHA's strategic and operational planning and on ANPHA's stakeholder engagement strategy. It has not provided advice on aspects such as strategic risks facing the organisation, as this has been provided by the Audit Committee. However, this could be considered in the future, should the CEO wish to obtain additional external views.

Expert and other advisory committees

3.25 The ANPHA Act also allows for the establishment of expert committees to advise the CEO and the Advisory Council on specific preventive health issues. The CEO has established advisory committees on the three risk areas on which it has been asked to focus at this stage—alcohol use, tobacco use and obesity. The committees have been provided with terms of reference, and appointments to the committees have been made using a list of criteria that focuses on appropriate experience and qualifications for the role. These criteria are publicly available on the ANPHA website.[77] The committees plan to meet three times a year.

3.26 Each of the committees has provided advice on key issues. For instance, the Expert Committee on Alcohol provided advice on ANPHA's submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs' Inquiry into Foetal Alcohol Spectrum Disorders. Similarly, the Expert Committee on Tobacco has provided advice on the continued development and implementation of the National Tobacco Campaign and on ANPHA's submission to the House of Representatives Standing Committee on Health and Ageing's inquiry into tobacco plain packaging.

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[76] ANAO, 2003, *Better Practice Guide on Public Sector Governance*, Guidance Paper No. 4, p. 3.

[77] ANPHA website, <http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/committees> [accessed 27 July 2012].

3.27 An additional committee, the National Evaluation Advisory Committee, was established in May 2011.[78] Its function is to provide advice to the CEO of ANPHA in relation to the national evaluation of the Agreement. The committee was involved in developing the scope of work for the National Evaluation; the assessment of tenders to develop the evaluation framework and strategy; and in providing feedback to ANPHA in finalising the accepted evaluation framework and strategy. Since its establishment and up to July 2012, the committee has met six times.

Audit Committee

3.28 A functioning and effective audit committee can play an important role in strengthening an agency's governance. In particular, an audit committee, tasked by a CEO with a charter can provide useful assistance on risk management practices, and the control environment, by providing independent assurance and advice on key elements of an agency's operations.[79]

3.29 ANPHA's Audit Committee is expected to provide oversight, assurance and advice on key elements of its operations. It has a charter, signed by the interim CEO, defining its terms of reference and tasking it with key responsibilities.[80]

3.30 Between ANPHA's establishment in January 2011 and March 2012, the Audit Committee met on four occasions, in accordance with its terms of reference. Items considered over that period included:

- ANPHA's Risk Management Policy, Plan and Register and Fraud Control Policy and Plan;
- standing items for review by the committee, including financial framework risks and risk management plan updates; and
- an internal audit plan for the agency.

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[78] Approval to establish the National Evaluation Advisory Committee was provided by ANPHA's interim CEO on 13 May 2011.

[79] ANAO Better Practice Guide—*Public Sector Audit Committees: Independent Assurance and Advice for Chief Executives and Boards*, August 2011, Canberra, p. 3.

[80] The charter was available to the Audit Committee by its second meeting in September 2011. The Audit Committee has received briefings from the CEO, Chief Finance Officer well as the Manager of the Operations and Knowledge Group. Briefings on ANPHA's Strategic and Operational Plans have also been provided.

3.31 One internal audit was planned and completed in 2011–12.[81] Key risk issues are programmed into an Audit Committee calendar. The Audit Committee has considered financial risks, in the context of the Australian Government's financial management framework, such as the operation of the special account, program expenditure profiles and Memorandum of Understanding services with DoHA.

Health and Safety Committee

3.32 To manage occupation health and safety, ANPHA has established a Workplace Health and Safety Committee and all staff are encouraged to participate in online health and safety training.[82] A plan detailing ANPHA's Health and Safety Arrangements for 2012–14 has also been prepared.[83]

Planning and reporting

Strategic and operational plans

3.33 The ANPHA Act requires ANPHA to prepare a strategic plan for a five-year period and an operational plan for the coming year for submission to the Minister for Health by 30th April each year. The Minister must seek the prior agreement of the COAG Standing Council on Health before approving the plans.[84] The CEO of ANPHA is also required to seek the advice of the Advisory Council in developing the strategic and operational plans. These requirements have been met to date.[85]

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[81] The internal audit reviewed 'ANPHA's management of its Special Account established under section 50 of the ANPHA Act 2010 in the context of the *Financial Management and Accountability Act 1997* and section 83 of the Australian Constitution'.

[82] The committee held its inaugural meeting on 26 March 2012. The committee has six members and is chaired by the Chief Operating Officer of ANPHA. At least three members of the committee must be elected staff health and safety representatives. The committee is required to meet at least once every three months.

[83] *ANPHA Health and Safety Arrangements 2012–2014*, July 2012.

[84] ANPHA Act, 2010, Sections 43 to 45.

[85] ANPHA submitted a draft strategic plan for 2011–15 and a draft operational plan for 2011–12 to the then Minister by 30 April 2011 in accordance with the ANPHA Act, but was unable to first consult the Advisory Council about the plans because the council had not been appointed at the time. However, at the first council meeting on 28 July 2011, comments on the plans were sought from members and these were then incorporated into amended plans, which were approved by the Minister in August 2011, after prior consideration and agreement out-of-session by the then Australian Health Ministers' Conference.

The Advisory Council considered the draft operational plan for 2012–13 in February 2012. The plan was approved by the Minister in May 2012, after having first being agreed out-of-session by the Standing Council on Health.

3.34 The strategic plan for 2011–15 identifies six high-level strategic goals, which are shown in Table 3.3.[86] Linking to these goals, key performance indicators and performance targets are detailed as part of ANPHA's operational plan.

Table 3.3

ANPHA's strategic goals

Description
Goal 1: Healthy public policy
Promote and guide the development, application, integration and review of public, organisational and community-based prevention and health promotion policies.
Goal 2: Health risk reduction
Provide policy advice and program leadership to support the development, implementation, evaluation and scaling-up of evidence-informed health promotion and health-risk reduction strategies for population groups across the lifespan and in a range of settings, with an initial focus on obesity, tobacco and harmful alcohol consumption.
Goal 3: Knowledge management
Drive the development of dynamic knowledge systems that enable evidence-informed policy and practice in prevention and health promotion across Australia.
Goal 4: Information and reporting
Guide improvements in national surveillance systems for prevention and health promotion and ensure that information on the progress of prevention and health promotion strategies is made readily available and regularly reported.
Goal 5: Capacity building
Build broad and comprehensive prevention and health promotion capacity.
Goal 6: Organisational excellence
Establish ANPHA as an innovative, reliable, transparent and accountable organisation, highly regarded by governments, partners, staff and the community with a strong national identity.

Source: ANPHA, *Strategic Plan 2011–2015*, p. 14.

3.35 The priorities and activities in the strategic and operational plans are consistent with ANPHA's functional responsibilities, which are listed in Table 3.2. Currently, ANPHA has been tasked by the Government with the development and implementation of evidence-based approaches to preventive health initiatives targeting obesity, harmful alcohol consumption and tobacco. These are also reflected in ANPHA's operational plans. Some stakeholders

[86] ANPHA, *Strategic Plan 2011–15*, p. 14.

commented that, while the focus on these major health risks is understandable in the initial stages of ANPHA's operations, in the longer term the focus could be broadened to include risk factors that affect the mental health of Australians and the health and wellbeing of young children.

3.36 ANPHA has progressed many of the tasks in its 2011–12 operational plan. Timelines were adjusted for some activities due to resource availability during the Agency's establishment phase, as well as an increased understanding of priorities obtained during this establishment period that enabled improved targeting of strategies. There has therefore been some slippage in completing some tasks and a change in scope in others, in particular, the Knowledge Hub, which is discussed in Chapter 5.

3.37 ANPHA intends to review its strategic plan in 2012–13 in light of experience during the first two years of operation and to help ensure the continuing relevance of the strategies against all key result areas. In this context, there would be merit in examining how it can best provide evidence-based advice on preventive health that meets the needs of all jurisdictions and deliver on its key result areas.

Informing ministers of key developments

3.38 A requirement under the FMA Act is that agencies must keep their responsible Ministers and the Finance Minister informed of the operations and financial affairs of the agency.[87]

3.39 Since the establishment of ANPHA in January 2011, ANPHA has given the Minister for Health several briefings on key ANPHA strategic policies and activities, including in relation to its preventive health role on alcohol, tobacco and obesity. The Minister was also provided at the end of July 2012 with the first full performance report against ANPHA's operational report for the 2011–12 financial year. This report will also be provided to the Standing Council on Health.

3.40 As noted at paragraph 2.37, quarterly performance reports are provided to the Standing Council on Health and the Australian Health Ministers' Advisory Council, as part of the COAG Health Information

[87] *Financial Management and Accountability Act 1997*, ss.44A(1)–(1)(b).

Reporting Framework. The Minister for Finance and Deregulation has also been consulted about matters, such as the guidelines for grant programs.

3.41 ANPHA's first annual report was required to be provided to the Minister for the 2011–12 financial year and was tabled in parliament in October 2012.[88] The report contains ANPHA's financial statements and an audit report on those statements.[89]

Risk management

3.42 Risk management is a key governance process that allows an organisation to identify, mitigate and manage risk. There was a set of initial risks in establishing ANPHA, many of which were managed by DoHA. A summary of ANPHA's approach to risk management and the ANAO's findings and comments on the elements of this approach are at Table 3.4.

Table 3.4

ANAO findings on ANPHA's risk management approaches

Risk management framework
Risk management policy
ANPHA's risk management policy currently focuses on key risk areas and high-level risks. Strategic-level risk plans for significant initiatives are provided to the Audit Committee for review in accordance with its charter. ANPHA also undertakes project-level risk management planning and reviews these at critical points to ensure that contemporary risks are captured.
Risk management plan
The risk management plan clearly defines responsibilities for all levels of staff, includes training to help ensure that ANPHA staff incorporate risk management into their work and requires managers to provide quarterly risk updates to the Manager, Operations and Knowledge.
Risk register
There is a risk register template to help ensure a standard process for the analysis and identification of new and emerging risks. Risk ratings are expected to be determined in accordance with the Risk Management standard ISO 31000:2009. The ANPHA Audit Committee examines new and emerging risks as a standing item at its meetings.

[88] As ANPHA had only been operating for six months in the 2010–11 financial year, it was only required to table audited financial statements for that year. The 2011–12 annual report covers performance for the 18 months period from 1 January 2011 to 30 June 2012.

[89] ANPHA Act, Section 53.

Risk management oversight
The risk management policy and plan are intended to be reviewed every two years. The Audit Committee oversees the implementation of the risk management plan and examination of the minutes of the committee's meetings indicates that it has been doing so.
Management of key risks
Fraud Control Plan and other financial risks
ANPHA's Fraud Control Plan identifies key fraud prevention measures and was approved by its Chief Executive in December 2011. The Audit Committee reviewed the draft plan and made suggestions for improvement which were incorporated. The Fraud Control Plan is generally in line with the Commonwealth Fraud Control Guidelines. ANPHA held two staff training sessions in fraud prevention in December 2011 and January 2012. Fraud control is now part of induction training for new staff and of ANPHA's revised Performance Development Scheme documentation.
Conflict of interest risks
Possible conflicts of interest by members of advisory and expert committees are managed through standing declarations to the Minister, before a person is appointed to a committee. Committee members also provide annual declarations on possible conflicts of interest and are required at the commencement of each meeting to declare any potential conflicts that might arise at that meeting. Unless judged as low conflict, committee members have been excluded from both discussion and decisions on the issues for which they had a conflict.
Outsourced services
The outsourcing of services to DoHA and other organisations is a risk because the CEO of ANPHA retains responsibility even though the functions have been outsourced. While documented in the risk register, it is not clear how those risks are managed. One risk mitigation strategy would be to ensure that DoHA's risk management is adequate for outsourced services provided to ANPHA.
Business continuity and disaster recovery
A business continuity plan is being developed and an executive succession plan and an information technology disaster recovery plan will form part of this plan. ANPHA has advised that the requirement to develop a pandemic response plan will be discussed by the Audit Committee.

Source: ANAO analysis of ANPHA's *Fraud Control Policy and Plan 2011–2014* and ANPHA's Risk Management Policy, Plan and Register.

3.43 ANPHA has established a generally sound framework for the management of risks, but needs to complete its business continuity and disaster recovery plans as soon as practicable. There would also be benefit in ANPHA satisfying itself that it has suitable risk mitigation strategies in place in relation to its outsourced services.

ANPHA's financial management arrangements

Chief Executive Instructions

3.44 Chief Executive Instructions (CEIs) are provided for in the FMA Act and Regulations[90] and agency heads may put in place policies that suit agency requirements. ANPHA's CEIs were signed by the CEO in November 2011 and are high-level instructions that are intended to be supported by more detailed finance business rules, manuals and supplementary guidelines. In August 2012, many of these supporting documents had not yet been prepared, with the exception of business rules for procurement and grants.

3.45 ANPHA's business rules are intended to: cover the principles for financial management and the methods required to accomplish those financial objectives or activities; impose compulsory obligations; and specify the explicit constraints on actions to ensure that breaches do not occur.[91] The CEO has delegated the development of business rules to the Chief Finance Officer.

3.46 The proposed manuals are intended to: define the financial processes and procedures; provide 'better practice' techniques to ensure the effective use of resources; and ensure the appropriate level of information for staff to achieve the required financial objectives or activities.[92] The supplementary guidelines are intended to be produced by program areas to meet specific needs as a supplement to the policy and procedures manuals and to address program-specific requirements.

3.47 The benefit of releasing internal business rules and manuals as soon as practicable was identified in the internal audit of the agency's special account, which was completed in June 2012. ANPHA advised that it had completed 51 of 60 business rules by 31 October 2012 and had committed to completing all business rules by 31 December 2012.

90 FMA Act, Section 52.

91 ANPHA CEIs, p. iii.

92 ibid.

3.48 ANPHA also advised the ANAO that a program of staff training has been initiated on procurement, grants and financial framework requirements.[93] There would be benefit in further considering staff training needs as other internal guidance is rolled-out.

Delegations

3.49 Good governance recognises that it is not possible for CEOs to undertake all actions on behalf of their agencies. Consequently, both the ANPHA Act and the FMA Act have provisions that allow the CEO of ANPHA to delegate powers to undertake specific functions. ANPHA's delegations are documented in two Financial Delegations instruments to meet these requirements.[94]

3.50 In the control framework audit of ANPHA's management of its special account, ANAO notes that a sample of transactions was examined for compliance with FMA Regulation 9 and 10 requirements.[95] All transactions were found to have been appropriately approved under FMA Regulation 9. One of these transactions also required FMA Regulation 10 approval and this was found to have been provided under that regulation. The ANAO examined FMA Regulation 9 approvals for research grants and found some scope for improved practices, as discussed in Chapter 5.

Certificate of Compliance

3.51 The Audit Committee reviewed and endorsed the 2010–11 and 2011–12 Certificates of Compliance, relating to compliance with the financial

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[93] ANPHA advised on 13 July 2012 that a series of seven two-hour training sessions were delivered to staff over the previous three months to raise awareness of their responsibilities in relation to the FMA Act, *Commonwealth Procurement Rules* and the *Commonwealth Grant Guidelines*. ANPHA had also adopted a policy that requires the Procurement, Grants and Probity Service to clear procurement and grant documentation prior to approval by the delegate.

[94] One financial delegation (*Chief Executive Officer's Financial Delegations Instrument, Delegation to ANPHA Officials 1 July 2012*) lists delegations to ANPHA staff under the FMA Act and FMA Regulations. The other (*Chief Executive Officer's Financial Delegations Instrument, Delegation to Officials of the Department of Health and Ageing 1 November 2011*) lists FMA Act and FMA Regulations delegations to DoHA officials who undertake functions for ANPHA under a service level agreement with DoHA and so need delegated authority to undertake those functions.

[95] FMA Regulation 9 requires that an approver must not approve a spending proposal unless the approver is satisfied, after reasonable inquiries, that giving effect to the spending proposal would be a proper use of Commonwealth resources (within the meaning given by subsection 44 (3) of the FMA Act). FMA Regulation 10 approval is required in circumstances where an agency has an insufficient appropriation of money to meet the full expenditure that might be payable under an arrangement.

management framework. The Certificates of Compliance were provided to the CEO, the Health Minister and the Finance Minister.[96]

Special account

3.52 ANPHA operates a special account established under the ANPHA Act and for the purposes of the FMA Act.[97] There were two transactions to the special account between the establishment of the agency in January 2011 and June 2012—$11.8 million in June 2011, being the remainder of ANPHA's 2010–11 administered Budget appropriation, and $3.8 million in February 2012 for the *Measure Up* and tobacco social marketing campaigns.

3.53 Agencies with special accounts must ensure that there are appropriate financial controls so that amounts are credited to the account where appropriate and expenditure from the account is in accordance with the purposes of the account. Amounts which can be credited and debited to the ANPHA special account are detailed in sections 51 and 52 of the ANPHA Act and are summarised in Table 3.5.

Table 3.5

Amounts that can be credited or debited to the ANPHA special account

Credited amounts	Debited amounts
Fees charged for services under Section 12 of the ANPHA Act.	Paying the costs, expenses and other obligations of ANPHA in relation to the CEO's functions
Amounts received from state and territory governments, industry, non-government organisations and the community sector where they may wish to contribute to ANPHA operations.	Paying remuneration and allowances of any person under the ANPHA Act.
The value of property purchased through the account.	Meeting the costs of administering the special account.
The amounts of any gifts or bequests received.	

Source: Summary from ANPHA Act, Sections 50, 51 and 52.

3.55 An internal audit of the control framework for ANPHA's special account was completed in June 2012 to ensure compliance with Section 83 of

[96] To provide assurance on the Certificates of Compliance, ANPHA advised that branch and section heads are required to sign-off on the compliance statements for their areas.

[97] ANPHA Act, Section 50. A special account is an appropriation mechanism that sets aside an amount through the Consolidated Revenue Fund that can be spent for specific purposes.

the Australian Constitution and Part 7 of the ANPHA Act.[98] The audit found, among other things, that the management of the special account was generally sound and, apart from the fact that some key documentation had still to be completed, the overarching framework appeared appropriate to manage key risks.

3.56 The internal auditors made three recommendations, relating to the need for ANPHA to document policies, procedures and processes to manage the special account and to reduce the heavy reliance on two key staff in relation to managing ANPHA's financial obligations. ANPHA has indicated that it has accepted and implemented the recommendations.

Support from the Department of Health and Ageing

3.57 DoHA provided significant initial support to ANPHA with staffing, funding and governance. This included assistance in developing the control documents, such as the Chief Executive Instructions, and in arranging accommodation for the agency and recruitment searches for the chief executive officer and members of the Advisory Council. Expressions of interest were also sought from DoHA staff to transfer to the new agency. Some staff were also transferred from DoHA to ANPHA following the transfer of responsibility for some functions, such as social marketing responsibilities.[99]

3.58 Continuing the support provided by DoHA in its establishment, ANPHA entered into a Service Level Agreement (SLA) with DoHA in September 2011 for the provision of some corporate services.[100] However, ANPHA remains responsible for the activities that are outsourced to DoHA. The SLA is flexible, and allows ANPHA to seek additional services, elect to take some services back in-house or outsource them elsewhere.[101]

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[98] Section 83 of the Australian Constitution provides that 'no money shall be drawn from the Treasury of the Commonwealth except under appropriation made by law'.

[99] In the transition period, the requirement under FMA Regulation 33 for accrued entitlements to be transferred to the gaining agency within 30 days requirement was not met. Officials of ANPHA and DoHA discussed the matter and since then accrued leave entitlements have been paid within 30 days of the invoice.

[100] DoHA, *Head of Agreement for the Provision of Corporate Services to ANPHA*, 21 September 2011. The service level agreement includes services such as payroll services, procurement services, information and communications technology services, property services and parliamentary services. There is a schedule to the heads of agreement for each individual service, which comprises a service outline, including the services provided with client and provider obligations, and payment arrangements.

[101] ANPHA must provide three months notice of service changes.

3.59 The SLA has some risks for ANPHA and this is recognised in the relevant risk management plan, although the risk mitigation strategies are not clearly articulated or documented. Risk mitigation is managed day-to-day by Service Liaison Officers in DoHA and ANPHA whose roles are to manage the contract.

3.60 SLA costs are invoiced monthly in arrears with payment required within 30 days of a correctly rendered invoice. Similar terms apply to discretionary tasks that ANPHA may request from DoHA. Charges for services are reviewed as part of the budget cycle by DoHA, and ANPHA is notified of any increases by 30thApril each year. There is a dispute resolution mechanism in the contract and ANPHA can terminate the contract with three months notice. This level of flexibility allows the agency to test the market and contract out some or all of the currently contracted services should it decide on this course in the future.[102]

[102] The SLA also allows for third-party contracts, which potentially increase the risk for ANPHA as they become more distanced from enforcement or corrective action for any problems, since a condition of the SLA is that ANPHA must accept that the services provided will be in accordance with the contract between DoHA and the third party. DoHA, *Head of Agreement for the Provision of Corporate Services to ANPHA, 21 September 2011*, Third Party Contracts, p. 2.

4. Preventive Health Social Marketing Campaigns

This chapter assesses ANPHA's management of social marketing campaigns funded through the Agreement, including the processes used to certify that the campaigns were undertaken in accordance with the Australian Government's Campaign Advertising Guidelines.

Introduction

4.1 The Australian Government has conducted social marketing campaigns over many years to encourage Australians to adopt healthy lifestyle practices and so lessen their risks of chronic disease and reduce demands on the Australian health system. Two risk factors targeted in government campaigns are those posed by being obese or overweight and from tobacco use. Given the importance of these risk factors, supplementary funding was provided in the Agreement to extend the Australian Better Health Initiative's *Measure Up* campaign (through a new *Swap It, Don't Stop It* campaign), aimed at decreasing Australians' rates of overweight and obesity, and the National Tobacco Campaign, aimed at reducing tobacco use.

4.2 There are two types of government advertising—non-campaign and campaign. Non-campaign advertising typically covers recruitment and notices about tenders, grants and public consultations[103], while campaign advertising involves a paid media placement and is designed to inform, educate, motivate or change behaviour.[104] The *Swap It, Don't Stop It* social marketing campaign and the National Tobacco Campaign are classified as campaign advertising.

4.3 Australian Government advertising campaigns, including social marketing campaigns, must follow established processes and procedures, which are designed to increase the likelihood of upholding the principles of probity and cost-effectiveness. The requirements for the development of advertising campaigns costing over $250 000 are shown in Figure 4.1. As

[103] Department of Finance and Deregulation, *Campaign Advertising* [Internet], 2012, available from <http://www.finance.gov.au/advertising/campaign-advertising.html>[accessed 21/6/2012]

[104] Department of Finance and Deregulation, *Guidelines on Information and Advertising Campaigns by Australian Government Departments and Agencies*, March 2010, paragraph 9.

expenditure on both *Swap It, Don't Stop It* and the National Tobacco Campaign were in excess of $250 000, the campaigns must adhere to the Australian Government's 2010 *Guidelines on Information and Advertising Campaigns by Australian Government Departments and Agencies* (Advertising Guidelines).

Figure 4.1

The campaign advertising framework: key elements

Key policy, administrative and legal arrangements

Campaign guidelines. FMA Act agencies must comply with the Advertising Guidelines and process requirements (including certification, publishing and reporting requirements) applying to information and advertising campaigns undertaken by agencies.

Financial management requirements. The FMA Act and FMA Regulations operate independently of the Advertising Guidelines and apply to all campaign spending proposals.

Agency responsibility. Agency chief executives are responsible for the development of advertising campaigns. They approve the materials and media plan and provide their minister with a certification that the campaign complies with the Advertising Guidelines and relevant government policies.

Independent Communications Committee (ICC). The ICC provides advice to agency chief executives on any campaign valued at more than $250 000, or when requested. It provides compliance advice on Principles 1-4 of the Advertising Guidelines, but not Principle 5 which is considered to relate to a chief executive's normal responsibilities. Chief executives must receive and consider the ICC's report on compliance with Principles 1 to 4 before certifying a campaign.

Peer Review Group. The group is intended to help agencies improve the quality of their advertising campaigns. It is chaired by the Department of the Prime Minister and Cabinet (PM&C) and co-chaired by Finance.

Ministerial approval. Ministers approve the development of campaigns, subject to funds being available through the budget process, and may choose to approve the launch of each campaign after it has been developed by the agency.

Publication and reporting. The agency is required to publish the chief executive certification and Finance is required to publish the ICC review on its website. Campaign details must be reported in agency annual reports.

Key procurement arrangements

Selection of consultants. The Communications Multi-Use List details all communications consultants working on government information and advertising campaigns. It must be used by agencies to select communications consultants for campaigns with expenditure over $250 000.

Media buying. The Central Advertising System consolidates government advertising expenditure with the goal of securing media discounts for government. Two 'master media agencies' are contracted by Finance to manage media planning, placement and rates negotiations with media outlets. The master media agency for all campaign advertising is Universal McCann.

Source: ANAO summary from <http://www.finance.gov.au/advertising/campaign-advertising.html>.

4.4 The Advertising Guidelines include five Information and Advertising Campaign Principles, as explained in Figure 4.2.

Figure 4.2

Advertising Guidelines principles and terms

Principle 1:	Campaign materials ***should*** be relevant to government responsibilities.
Principle 2:	Campaign materials ***should*** be presented in an objective, fair and accessible manner and be designed to meet the objectives of the campaign.
Principle 3:	Campaign material ***should*** be objective and not directed at promoting party political interests.
Principle 4:	Campaigns ***should*** be justified and undertaken in an efficient, effective and relevant manner.
Principle 5:	Campaigns ***must*** comply with legal requirements and procurement policies and procedures.

Must—a mandatory obligation that must be complied with in all circumstances.
Should—a matter of sound practice for which agencies should have regard.

Note: While the principles contain a hierarchy of requirements using 'must' and 'should', the Advertising Guidelines do not contain definitions of these terms. In considering the terms, the ANAO has applied definitions for the terms based on well-established guidance from the *Commonwealth Grant Guidelines* and the *Commonwealth Procurement Rules*. The ANAO's analysis is discussed at length in Report No. 24, 2011–12, pp. 64–68.

Source: ANAO analysis of Finance's *Guidelines on Information and Advertising Campaigns by Australian Government Departments and Agencies*, March 2010, paragraphs 18 to 35 (emphasis added).

4.5 Under the Advertising Guidelines, chief executives are responsible for their agency's compliance with specified procedures, applicable laws and government policy. The chief executive then certifies compliance with Principles 1 to 5 and provides this certification to the relevant minister who can subsequently approve and/or launch the campaign.[105] The process for the development and launch of campaigns in excess of $250 000 is shown in Table 4.1.

[105] ANAO, Audit Report No.24 2011–12, *Administration of Government Advertising Arrangements: March 2010 to August 2011,* February 2012, Canberra, p. 16.

Table 4.1

Development of Government Advertising Campaigns over $250 000

Process for Developing Advertising Campaigns
The minister of the relevant department or agency (agency) agrees to the development of a campaign, subject to funds being available.
The agency informs Finance of the impending advertising campaign.
Finance can assist the agency in the selection of the research consultant from the Communications Multi-Use List.
The agency develops the campaign, which is reviewed at different stages by the Peer Review Group and the Independent Communications Committee.
The minister of the agency developing the campaign approves the launch of the campaign after receiving the chief executive's certification.

Source: ANAO summary of *Guidelines on Information and Advertising Campaigns by Australian Government Departments and Agencies*, March 2010.

4.6 The ANAO reviewed the certification documents and the *Swap It, Don't Stop It* campaign's adherence to the principles outlined in the Advertising Guidelines to evaluate compliance with the Advertising Guidelines and the effectiveness of ANPHA's management of the Spring 2011 and Autumn 2012 campaign rounds. The ANAO did not carry out a comprehensive examination of the National Tobacco Campaign's compliance with the Advertising Guidelines.[106]

Overview of the *Swap It, Don't Stop It* campaign

4.7 The *Swap It, Don't Stop It* campaign was launched in October 2008. Under the Agreement, COAG initially allocated $41 million in funding from 2009–10 to 2012–13 for national social marketing activities aimed at decreasing the rates of overweight and obesity in Australians, and $18 million to states and territories for local activities that complement the national campaign.[107]

[106] As discussed in paragraph 3.14, the National Binge Drinking Strategy expansion measures are not part of the Agreement, and consequently the audit did not examine associated social marketing campaigns.

[107] National Partnership Agreement on Preventive Health Implementation Working Group, *National Partnership Agreement on Preventive Health—National Implementation Plan 2009–2015*, June 2009, p. 77. The October 2012 Mid-Year Economic and Fiscal Outlook subsequently reduced funding for the Australian Government's *Swap It, Don't Stop It* campaign by $10.5 million in 2012–13, to total $30.5 million from 2009–10 to 2012–13.

4.8 *Swap It, Don't Stop It* aimed to promote small, everyday changes that can be made towards attaining 'a healthier lifestyle, without losing all the things you love'.[108] It features Eric, a likeable but overweight animated blue balloon character. On television, in print and on the radio, Eric urges Australians to make simple lifestyle changes by swapping one unhealthy practice or activity for a healthier practice or activity.[109] Table 4.2 identifies examples of 'swaps' encouraged in the campaign.[110]

Table 4.2

***Swap It, Don't Stop It* encouraged swaps**

Practice or activity	Swap
Portion control	Big for small
Occasional treats	Often for sometimes
Nutritional quality	Fried for fresh
Physical activity	Sitting for moving, watching for playing

Source: Australian Government, <http://www.swapit.gov.au> [accessed 11 October 2012].

4.9 *Swap It, Don't Stop It* was released in three rounds—Autumn 2011, Spring 2011 and Autumn 2012. The ANAO focused on those rounds for which ANPHA had prime responsibility, namely the Spring 2011 and Autumn 2012 rounds.[111]

4.10 The objectives of *Swap It, Don't Stop It* and other key features are summarised in Table 4.3.

[108] Australian National Preventive Health Agency, *Become a Swapper* [Internet], Canberra, 2012. Available from:<http://www.measureup.gov.au/internet/abhi/publishing.nsf/Content/become-a-swapper-lp 22/5/2012> [accessed 22/5/2012].

[109] Australian National Preventive Health Agency, 'Swap It Don't Stop It' [Internet], Canberra, March 2012, available from <http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/campaigns> [accessed 21/5/2012].

[110] Indigenous Australians were targeted through a complementary *Tomorrow People* program and other activities funded by the Agreement on closing the gap in Indigenous health outcomes. Non-English speaking background communications activities also complemented the mainstream campaign and were implemented simultaneously. Department of Health and Ageing Social Marketing Unit, *Measure Up Social Marketing Strategy 2009–2013 Phase Two*, June 2010, pp. 37–38.

[111] Due to the delay in the establishment of ANPHA, DoHA began work on *Swap It, Don't Stop It* and was primarily responsible for the Autumn 2011 round. ANPHA had joint responsibility with DoHA for the Spring 2011 round, and was solely responsible for the Autumn 2012 round.

Table 4.3

Key features of the *Swap It, Don't Stop It* advertising campaign

Summary		
Objectives	To encourage Australians to make and sustain changes to their behaviour, such as increased physical activity and healthier eating behaviours, progressing towards recommended healthy levels. To contribute to reducing morbidity and mortality due to lifestyle-related chronic disease in Australian adults.	
Timing	• Spring 2011: 11 September 2011 to 24 December 2011 • Autumn 2012: 25 March 2012 to 2 June 2012	
Target Audience	• Primary target audience: Parents aged 25–50 years • Secondary target audience: Adults aged 45–65 years • Tertiary target audience: Health professionals Activities were particularly directed towards families and 'at risk' groups in the primary and secondary target audiences, including young women of child bearing age, people in regional communities and socially disadvantaged groups, such as sole parents and people with intellectual disabilities. Indigenous Australians and people from non-English speaking backgrounds were special target audiences.	
Media Expenditure (Advertising Reports)	July 2010–June 2011	$9.8 million
	July 2011–June 2012	$8.6 million
Campaign Budget	2009–10	$1.4 million
	2010–11	$13.3 million
	2011–12	$13.27 million(A)
	2012–13	$2.55 million
	Total	**$30.52 million**

Notes: (A) The original 2011–12 campaign budget was reduced by $1.64 million to $11.63 million following a review of government advertising which affected the Autumn 2012 *Swap It, Don't Stop It* round.

(B) The original 2012–13 campaign budget of $13.66 million was reduced by $10.5 million to $2.55 million following the October 2012 Mid-Year Economic and Fiscal Outlook.

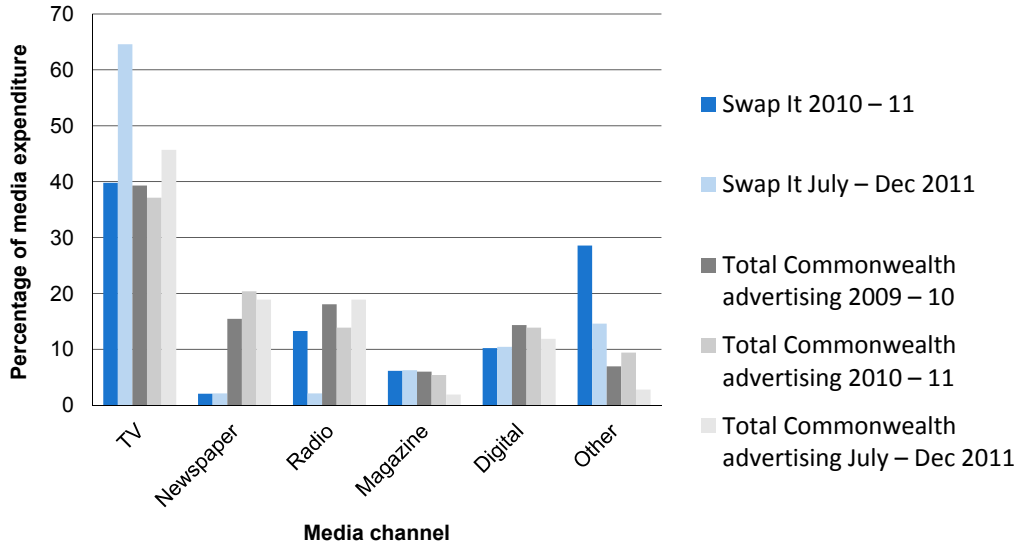
Source: ANAO examination of *Swap It, Don't Stop It* campaign documents.

Media expenditure on the *Swap It, Don't Stop It* campaign

4.11 Figure 4.3 identifies the percentage of anticipated expenditure across the chosen media channels for *Swap It, Don't Stop It* compared with the overall percentage of media placement expenditure per media channel by the Australian Government in 2009–10, 2010–11 and 2011–12. It indicates that the major component of total media expenditure was allocated to television-based advertising. Very little of the campaign advertising was spent on newspaper and radio channels.

Figure 4.3

Media expenditure for the *Swap It, Don't Stop It* campaign



Note: 'Other' refers to non-English speaking background, Indigenous, out-of-home and print-handicapped media.

Source: ANAO analysis of Government Advertising Reports.

4.12 There was a reduction of $1.64 million in the media spend for the Autumn 2012 round of *Swap It, Don't Stop It*.[112] This resulted from an Australian Government advertising expenditure review. Given the timing of the advice regarding the reduced media spend, the first round of existing creative content could not be cancelled without incurring substantial penalties.

[112] The April–June 2012 period media spend reduced from $2.9 million to $1.26 million.

The remaining budget, after pre-existing commitments, would only have allowed for one week's airtime for the new creative content, which was not considered to be cost-effective.[113] As a result, the campaign was aired using only existing (and not new) creative content in late March to early April 2012. A minimal degree of non-television media continued until early June 2012.

The *Swap It, Don't Stop It* campaign's compliance with the Advertising Guidelines

4.13 The ANAO assessed ANPHA's administration of the development and implementation of the Spring 2011 and Autumn 2012 rounds of the *Swap It, Don't Stop It* campaign against the mandatory publication and reporting requirements specified in paragraphs 14 and 17 of the Advertising Guidelines, and the five Information and Advertising Campaign Principles. The process through which *Swap It, Don't Stop It* was certified as compliant with the Advertising Guidelines was assessed by reviewing the statements of compliance provided by the agency to the Independent Communications Committee (ICC); the formal record of the ICC's conclusions; the chief executive's certification statement and related records of the ICC, Finance, DoHA and ANPHA.

Compliance with the certification, publication and reporting requirements of the Advertising Guidelines

4.14 Table 4.4 summarises the ANAO's findings. In summary, the ANAO found that ANPHA complied with the certification, publication and reporting requirements in paragraphs 14 and 17 of the Advertising Guidelines.

[113] Universal Media advised that one week of television was not sufficient to ensure effective reach and awareness for new creative materials.

Table 4.4

Compliance with certification, publication and reporting requirements for the Spring 2011 and Autumn 2012 rounds of the *Swap It, Don't Stop It* campaign

Element	Status	Was it done?	Date completed / ANAO comments
Paragraph 14. For advertising campaigns of $250 000 or more:			
The Independent Communications Committee *will* consider the proposed campaign and provide a report to the chief executive on compliance with Principles 1, 2, 3 and 4 of the Advertising Guidelines. Agencies *will* be responsible for providing a report to their chief executive on campaign compliance with Principle 5 of the Guidelines.	Mandatory	✓ ✓	ICC Report Spring 2011: 28 July 2011 Autumn 2012: 28 March 2012 Agency report Spring 2011: 19 August 2011 Autumn 2012: N/A[A]
Following consideration of the reports on campaign compliance, the chief executive *will* certify that the campaign complies with the Guidelines and relevant government policies.	Mandatory	✓	Spring 2011: 21 Aug 2011 Autumn 2012: N/A[(A)]
The chief executive *will* give the certification to the relevant minister who may launch the campaign or approve its launch.	Mandatory	✓	Spring 2011: Joint certification by Secretary of DoHA and Acting CEO of ANPHA, March 2011. Autumn 2012: 30 March 2012[(B)]
The chief executive's certification *will* be published on the relevant department's website when the campaign is launched.	Mandatory	✓	Both certifications are on the www.swapit.gov.au website (not the ANPHA website). Earliest certification is also on the DoHA website.
The conclusions of the Independent Communications Committee *will* be published on Finance's website after the campaign is launched.	Mandatory	✓	Spring 2011: 12 September 2011 Autumn 2012: 28 March 2012

Element	Status	Was it done?	Date completed / ANAO comments
Paragraph 17. Chief executives *will* ensure that:			
Research reports for advertising campaigns with expenditure of $250 000 or more are published on their agency's web site following the launch of a campaign *where it is appropriate to do so*.	Not mandatory due to caveat	✓	ANPHA's website has the final report of the waves 5 & 6 evaluation released February 2012. *Measure Up* website has the *Swap It, Don't Stop It* formative report.
Details of advertising campaigns undertaken *will* be published in agency annual reports.	Mandatory	✓	DoHA 2010–11 Annual Report (p. 82).

Notes: (A) As there were no changes to the creative material in the Autumn round, re-certification of the campaign was not required.

(B) The Minister was advised that re-certification was not required, and given a copy of the original co-certification by ANPHA's acting CEO as campaign custodian and the Secretary of DoHA as policy owner.

Source: ANAO analysis.

4.15 Finance reported details of the *Swap It, Don't Stop It* campaign in the report *Campaign Advertising by Australian Government Departments and Agencies 2010–11*, which is appropriate as the campaign was launched during this period.

Compliance with the five Information and Advertising Campaign Principles

4.16 In March and July 2011 and March 2012, the ICC confirmed that it had reviewed the *Swap It, Don't Stop It* campaign's compliance and concluded that it complied with Principles 1 to 4 of the Advertising Guidelines.[114]

4.17 The ANAO's assessment of *Swap It, Don't Stop It's* compliance with the Information and Advertising Campaign Principles is summarised at Table 4.5.

[114] ICC letters dated 10 March 2011, 28 July 2011 and 28 March 2012, available at <http://www.finance.gov.au/advertising/icc/doha.html> [accessed on 7 August 2012].

Table 4.5

Swap It, Don't Stop It—assessment of compliance with the five Information and Advertising Campaign Principles

Information and Advertising Campaign Principles / ANAO assessment and comment
Principle 1: Campaigns *should* be relevant to government responsibilities
Assessment: ANPHA's statements of compliance to the ICC and the chief executive certifications contained reasonable representations of *Swap It, Don't Stop It's* compliance with Principle 1.
Comment: The *Swap It, Don't Stop It* campaign is directly related to the Australian Government's role and commitments under the Agreement in addressing the rising prevalence of lifestyle-related chronic diseases. It is a Commonwealth responsibility under the Agreement, with administered funds being appropriated to ANPHA under Appropriation Bill No.1.
Principle 2: Campaign materials *should* be presented in an objective, fair and accessible manner and be designed to meet the objectives of the campaign
Assessment: ANPHA's statements of compliance to the ICC and the chief executive's certification contained reasonable representations of *Swap It, Don't Stop It's* compliance with Principle 2.
Comment: A number of external technical experts were consulted to provide advice and guidance on key references used to inform creative materials. Health-related statements in the campaign were deemed factually accurate in the 'Approval of *Measure Up* Phase Two Campaign Statements' signed by DoHA's Chief Medical Officer. ANPHA's Obesity Policy Section also reviewed and approved the campaign material for technical accuracy. The ANAO indentified some minor referencing inaccuracies in this Campaign Statements document, which did not affect the substance of the statements. The Statement of Compliance did not contain an evidence matrix outlining the factual basis for factual statements made in *Swap It, Don't Stop It*'s creative materials. To strengthen transparency in the application of Principle 2, ANPHA should include in future compliance statements a clear linkage between information presented as fact in a government advertising campaign and the sources cited in support of that information. There was extensive concept testing to support the approach and messages delivered in the campaign. A matrix of research recommendations (such as the wording of advertisements) and ANPHA's response were not provided and the ICC has asked that this be provided in future. The needs of disadvantaged groups, in particular Indigenous Australians, people from non-English speaking backgrounds and people with intellectual disabilities, were identified and targeted.

Principle 3: Campaign materials *should* be objective and not directed at promoting party political interests
Assessment: ANPHA's statements of compliance to the ICC and the chief executive's certification contained reasonable representations of *Swap It, Don't Stop It's* compliance with Principle 3.
Comment: The messages were only directed at actions that people can take to improve their health and wellbeing and so reduce the risk of chronic disease. No party political issues were identified.
Principle 4: Campaigns *should* be justified and undertaken in an efficient, effective and relevant manner
Assessment: ANPHA's statements of compliance to the ICC and the chief executive's certification contained reasonable representations of *Swap It, Don't Stop It's* compliance with Principle 4.
Comment: This campaign formed part of the Commonwealth's obligations in the Agreement, which in turn was prompted by a perceived need by the Commonwealth, state and territory governments for lifestyle changes aimed at reducing the occurrence of chronic diseases in the community. Concept testing with groups of the intended recipients showed that the *Swap It, Don't Stop It* campaign messages 'would be likely to initiate some level of behavioural change'. Advertising rounds have continued to be launched on a seasonal basis, enabling evaluations to be undertaken of comparable campaigns. Existing media was used in the Spring 2011 and Autumn 2012 rounds. The waves 5 and 6 evaluations indicated that the existing creative content had shown no signs of wear, and that it was cost efficient to continue with that creative content.
Principle 5: Campaigns *must* comply with legal requirements and procurement policies and procedures
Assessment: ANPHA's statements of compliance to the ICC and the chief executive's certification contained reasonable representations of *Swap It, Don't Stop It's* compliance with Principle 5.
Comment: DoHA's Legal Services Branch and the Australian Government Solicitor advised that the campaign was compliant with Principle 5 and the Electoral Guidelines. The ANAO examined procurement documents from three companies. In most cases, DoHA had initiated the contracts with these social marketing agencies and responsibility was transferred to ANPHA in a Deed of Variation. The ANAO has not identified any issues with ANPHA's adherence to the Commonwealth Procurement Rules. ANPHA advised the ANAO that it did not produce an annual procurement plan for the 2011–12 financial year because, being a new agency, it was not in a position to predict future procurement needs. ANPHA's annual procurement plan for 2012–13 has been released on the AusTender website. The ANAO identified an oversight in the agency's procurement reporting required by the Murray Motion (Senate Order 192). A number of procurements over $100 000 in 2011 were not reported by either DoHA or ANPHA as both agencies assumed the other had reported them. ANPHA has since included the relevant *Swap It, Don't Stop It* contracts as part of its 2011–12 financial year Senate Order reporting.

Source: ANAO analysis *of Swap It, Don't Stop It* campaign documents.

4.18 In summary, while the ANAO found that the chief executive's certifications for the Spring 2011 and Autumn 2012 rounds of the campaign contained reasonable representations of compliance with the Information and Advertising Campaign Principles, there was scope to strengthen transparency in the application of Principle 2.

Recommendation No.2

4.19 To provide additional support to the agency's chief executive and the Independent Communications Committee, the ANAO recommends that the Australian National Preventive Health Agency includes in future compliance statements a document that clearly correlates the evidence for factual statements appearing in campaign creative materials with those campaign statements.

ANPHA response

4.20 Agreed.

Effectiveness of the *Swap It, Don't Stop It* campaign

4.21 Principle 2 of the Advertising Guidelines provides that campaigns should be evaluated to determine their effectiveness (paragraph 33).

4.22 The evaluation of the 2011 Autumn and Spring rounds of the *Swap It, Don't Stop It* campaign comprised two waves[115] of post-campaign tracking surveys. The surveys were facilitated by computer-assisted telephone interviews with national samples of adults aged 25–65 years, residing in private households and contactable by landline telephones.[116] Overall, the evaluations found that awareness of the campaign had increased by six percentage points in both the primary and secondary audiences (69 per cent and 59 per cent respectively) from the Spring 2011 round, despite a lower media spend in the later round. The evaluation found that there was room to

[115] These evaluations of the *Swap It, Don't Stop It* campaign are called waves 5 and 6. Waves 1-4 were conducted on the Measure Up, Phase 1 campaign. As the evaluations are conducted by the same company, and are seasonally consistent, some of the data is comparable. The wave 1 survey (October 2008) is used as a baseline in the wave 5 (July 2011) and wave 6 (November 2011) evaluation.

[116] The Social Research Centre, *Australian National Preventive Health Agency, Evaluation of the Swap It, Don't Stop It Social Marketing Campaign*, February 2012.

improve the cut-through and reach of the campaign with minimal change to creative content.[117]

4.23 The behavioural objective of the *Swap It, Don't Stop It* campaign was to 'increase the likelihood that adults will reduce their risk of chronic disease by making positive changes to their levels of physical activity and healthy eating in line with national, evidence-based guidelines'.[118] The waves 5 and 6 evaluations tested the degree of behavioural change and found that 36 per cent of those who had seen the campaign had taken at least one action towards a healthier lifestyle, such as swapping unhealthy lifestyle choices, with increased physical activity, decreased snacks/fast food consumption or increased fruit/vegetable consumption.

4.24 Table 4.6 illustrates other key aspects that were evaluated in waves 5 and 6. These statistics reveal a number of positive changes in both awareness and intention to change lifestyle behaviours. However, awareness of some behavioural changes required to reduce the risk of chronic disease had decreased since the baseline was recorded, although only a few of these results were statistically significant (marked by an asterisk).[119] One statistically significant result was a decrease in the mean hours walked each week from 3.54 hours in October 2008 to 2.49 hours (wave 5) and 2.67 (wave 6).[120]

[117] ibid., p. 56.

[118] *Measure Up Social Marketing Strategy 2009–13 Phase Two*, p. 31.

[119] Statistically significant data are results that the evaluators are more than 95 per cent certain are not due to chance.

[120] The Social Research Centre, op. cit., p. 42.

Table 4.6

Key findings from the waves 5 and 6 evaluation report of the *Swap It, Don't Stop It* campaign

Response:	Wave 1 (baseline)	Wave 5	Wave 6
Recall of advertising about lifestyle, healthy weight and chronic disease	72%	67%*	65%*
Spontaneous recall of the 'Swap It' campaign	-	16%	19%
Spontaneous message recall 'swaps framework'	-	88%	91%
Taken at least one action because of the campaign	-	32%	36%
This campaign ... makes me more likely to try to improve my health	-	65%	65%
Attempted to decrease fast or snack food consumption in the last six months	44%	42%	48%
Agreement with statements regarding behaviours of importance in preventing chronic disease			
Maintaining a healthy weight	85%	85%	83%
Doing 30 minutes of physical activity per day	81%	78%*	77%*
Eating five serves of vegetables every day	68%	67%	62%*
Maintaining a waist measurement of no more than 80cm (female) or 94cm (male)	55%	57%	59%
Agreement with statements about health, lifestyle and chronic disease			
I am going to change my lifestyle to become healthier	70%	74%	75%
Making small changes to what you eat or how physically active you are will decrease your risk of chronic disease	-	94%	94%

Note: * Data are statistically different from the baseline recorded in October 2008.

Source: The Social Research Centre, *ANPHA, Evaluation of the Swap It, Don't Stop It Social Marketing Campaign (Wave 6)*, February 2012. Available from <http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/campaigns>

4.25 Supportive campaign material that was not analysed in the waves 5 and 6 evaluation included the website and a free *iPhone* app (application), which contains a range of functions in line with the core

swapping message.[121] Using Google analytics, ANPHA does monitor the *iPhone* app and Facebook site to determine downloads/visits. At March 2012, there had been 48 500 downloads of the app and between the launch of the *iPhone* app on 18 March 2011 and 26 March 2012 there were more than 149 660 swaps suggested on the website. There is currently no plan to evaluate the online tools, despite around $395 000 having been spent on this area at 30 April 2012.[122] The ANAO suggests that ANPHA consider including the online tools in future evaluations of the campaign.

4.26 Television advertising continued to be the most remembered media for the *Swap It, Don't Stop It* campaign (61 per cent, up 13 per cent from the wave 5 survey).[123] The Autumn 2011 round of television media had 900 Target Audience Rating Points (TARPS)[124] split over two time periods, while the Spring 2011 round had 650 TARPS over three weeks.[125] The evaluation found that the 'focused' approach used in the Spring 2011 round was more successful at reaching the target audience. This process shows an effort to learn from past evaluations to improve effectiveness and the cost efficiency of the campaign.

4.27 Other indications of the effectiveness of these campaigns (and other related measures) will be provided once the results of the current National Health Survey are available from October 2012 and subsequently analysed, and after completion of ensuing National Health Surveys, which are usually conducted every two years.

[121] Users can track their progress and earn 'badges' as they reach their swapping milestones, choose healthy ingredient alternatives, browse or submit swaps and set up reminders to give handy swap options at any time of day.

[122] ANPHA Budget Estimates, *Swap It Don't Stop It* Website, Policy and Programs Brief—E12-311, May 2012, p. 2.

[123] The Social Research Centre, op. cit., p. 13.

[124] If an advertisement is watched by 10 per cent of the population, it represents 10 TARPS. Each advertising session will be worth a specific number of TARPS, when combined into an advertising round this will provide the total number of TARPS.

[125] The Social Research Centre, op. cit., p. 4.

5. Preventive Health Research and Other Preventive Health Initiatives

This chapter assesses the effectiveness of ANPHA's strategies for facilitating research into health promotion and preventive health, including through a competitive grants program, and the implementation of other initiatives under the Agreement.

Introduction

5.1 As indicated in Chapter 1, the Australian Government has responsibility for eight of the 11 initiatives under the Agreement, including the establishment of ANPHA and the conduct of social marketing campaigns that were discussed in the previous two chapters. Other key Australian Government responsibilities under the Agreement are:

- ANPHA's role in preventive health research and its management of grants for preventive health research through the new Preventive Health Research Fund;
- the implementation of the Healthy Communities initiative and, in particular, DoHA's management of grants to local government areas (LGAs) and other non-government organisations under this initiative; and
- the Australian Health Survey, the workforce audit and strategy and the National Eating Disorders Collaboration.

Preventive health research

5.2 As noted at Table 3.2, one of ANPHA's responsibilities under the ANPHA Act is to facilitate national preventive health research infrastructure. To assist it, ANPHA has appointed an expert committee on research. The expert committee has provided advice on the development of the research strategy and consideration of the research grants. The committee met on four occasions in 2011–12, its first year of operation.

5.3 Consistent with the requirement to facilitate national preventive health research infrastructure, one of ANPHA's strategic goals for 2011 to 2015 is to:

> drive the development of dynamic knowledge systems that enable evidence-informed policy and practice in prevention and health promotion across Australia.[126]

5.4 In its operational plans for 2011–12 and 2012–13, ANPHA has identified three key result areas under this strategic goal. Table 5.1 shows these result areas, and progress against them to July 2012.

Table 5.1

Progress against ANPHA's key result areas for knowledge management to July 2012

Key result area	Key deliverables	Progress
KRA 3.1 Prevention and health promotion research *Ensure prevention and health promotion policies and programs are underpinned by the best possible evidence with world-class, sustainable research capacity in Australia.*	Development and promotion of a *National Preventive Health Research Strategy 2012–2015*	An interim research strategy was completed in 2011 and the final *National Preventive Health Research Strategy 2012–2015* is now planned for completion in March 2013. A consultant is being engaged to support the analysis of submissions from stakeholders who were asked to identify priority areas and actions in order to prepare the final strategy. The strategy is being developed in consultation with the National Health and Medical Research Council (NHMRC).
KRA 3.2 Evidence analysis and dissemination *Collect, analyse, interpret and disseminate knowledge for improving and expanding prevention and health promotion practice across sectors and settings.*	Development of a national internet-based knowledge hub for prevention and health promotion information.	ANPHA has developed a knowledge hub. This is not a self-contained source of knowledge on disease prevention and health promotion, as had originally been anticipated, however, because ANPHA concluded that it would be more cost-effective to provide links to selected existing prevention and health promotion websites that align with ANPHA's prevention and health promotion goals. ANPHA plans to continue to develop its website as a means of sharing information on disease prevention and health promotion and enabling people to engage with its work.

[126] Australian National Preventive Health Agency, *Strategic Plan 2011—2015*, Goal 3, Knowledge Management, p. 14.

Key result area	Key deliverables	Progress
	Manage the 2011–2015 Preventive Health Research Fund grants.	An initial round of 13 research grants, totalling $3.74 million, was announced by the Minister for Health, the Hon Tanya Plibersek, MP, and the Minister for Social Inclusion, the Hon Mark Butler, MP, on 6 March 2012. ANPHA's management of the Preventive Health Research Fund is examined further below.
KRA 3.3 Prevention and health promotion evaluation *Promote and support evaluation and the development of an evaluation culture in all programs and policies related to prevention and health promotion, in order to build evidence and capacity.*	Overseeing the national evaluation of the National Partnership Agreement on Preventive Health.	ANPHA has commissioned work on developing a framework for the national evaluation on the Agreement. It is planning to appoint an evaluator by March 2013.

Source: ANAO analysis of ANPHA's key deliverables and progress.

5.5 While ANPHA has made progress in developing its research strategy, it will still be some time before this is completed. The agency is consulting widely in the development of the strategy as this is a critical element in developing a robust research strategy. Nonetheless, the priority for ANPHA is to complete the strategy as quickly as possible and to start implementing it so that early tangible results can be realised.

Preventive Health Research Fund

5.6 The Agreement provided $13.08 million for the Preventive Health Research Fund and, as noted in Table 5.1, an initial round of 13 grants totalling $3.74 million was announced on 6 March 2012. The NHMRC advised ANPHA on the development of the grant round and provided a resource to assist in the management of the peer review process.

5.7 In making grants under ANPHA's Research Grants Program, the agency was required to comply with the *Commonwealth Grant Guidelines* (CGGs). The ANAO assessed the processes used by ANPHA in making these

grants against the key requirements of the CGGs (listed in Table 5.2) and other requirements associated with them.[127]

Table 5.2

Key requirements of the *Commonwealth Grant Guidelines*

CGG reference	CGG requirement
Paragraphs 3.16 and 3.17	Under the financial management framework, there is an overarching requirement to manage an agency's affairs efficiently, effectively, economically and ethically within the context of the Australian Government's policy framework. The policy requirements relating to grants administration include the guidelines applying to granting activity.
Paragraph 3.23	Agencies *must* develop grant guidelines for new grant programs, and make them publicly available (including on agency websites) where eligible persons and/or entities are able to apply for a grant under the program.
Paragraph 3.24	Agencies *must* ensure that grant guidelines and related operational guidance are in accordance with the CGGs.
Paragraph 3.22	The Australian Government has agreed that the Expenditure Review Committee (ERC) will consider guidelines for new grant programs. Where a change is proposed to the guidelines for an existing grant program, agencies should consult with Finance on whether the proposed change will give rise to the need for ERC consideration of the guidelines. Although the Guidelines have not been amended to reflect this, in September 2010 the requirement for guidelines for new programs to be submitted to ERC for consideration was changed. The need for guidelines for new programs to be submitted to the ERC is now considered on a case-by-case basis, on the basis of a risk assessment conducted by the agency.
Paragraph 4.2	An agency must publish, on its website, information on its individual grants no later than seven working days after the funding agreement for the grant takes effect.
Page 14	Agencies should have regard to sound practices set out in the CGGs when implementing the seven key principles of grants administration.

Source: Department of Finance and Deregulation, *Commonwealth Grant Guidelines, Policies and Principles for Grants Administration*, July 2009, pp. 9 and 11 and ANAO, *Development and Approval of Grant Program Guidelines*, Audit Report No.36 2011–12, pp. 42 and 58–61.

5.8 The processes used by ANPHA to invite and assess applications for all research grants and their compliance with the CGGs are shown at Table 5.3.

[127] ANPHA also provided 26 community level grants in 2011–12 under the Government's National Binge Drinking Strategy. However, this strategy is not part of the Agreement and so was not examined in this audit.

Table 5.3

ANPHA's administration of the 2011–12 round of research grants

Step	ANAO comment
Development of grant guidelines for the 2011–12 funding round	ANPHA developed the research grant guidelines in consultation with Finance and PM&C. ANPHA advised the Minister that these departments had assessed the risks as low and that she could therefore approve the guidelines for this new grant program. The guidelines were approved by the then Minister for Health and Ageing in August 2011 and were submitted to the Minister for Finance and Deregulation for consideration. The guidelines were made available on the ANPHA website when applications for grants were invited.
Inviting applications	Applications opened on 3 September 2011 and closed on 30 September 2011. A total of 207 applications were received.
Appraisal and shortlisting of applications	All applications were initially reviewed by staff from ANPHA and NHMRC, who provided preliminary assessments of each application. They were then examined by the Research Committee to shortlist the applications that would be peer reviewed. A total of 29 applications were selected for peer review.
Peer review of applications	Each short-listed application was sent to at least two peer reviewers. The peer review reports, and rebuttals by applicants, were then considered by the Research Committee.
Verification of applications for funding	Short-listed applications were reviewed by the Research Committee and 13 applications were recommended for funding to the ANPHA CEO. Following this, a detailed assessment report was provided to the CEO.
Approval of research grants	The Minister for Health approved grants funding to all 13 recommended applicants in January 2012. The CGGs require ministers who approve grants within their electorates to advise the Finance Minister of details of the grant. One grant recipient, a researcher at the University of Sydney, was located in the Minister's electorate and the Minister advised the Finance Minister of this on 23 February 2012.
FMA Regulation 9 and 10 approvals	ANPHA did not require FMA Regulation 10 approval as sufficient funding to meet the cost of the grants over the period of the grants was available in the agency's special account. FMA Regulation 9 approval of the research grants is examined in paragraphs 5.9 to 5.17.
Entering into funding agreements	ANPHA has completed contracts with all organisations.
Publication of grants	Unless otherwise approved by the Finance Minister, the CGGs require details of all grants to be published on an agency's website no later than seven working days after the funding agreement for the grant takes effect, and retained on that website for at least two financial years. The Minister for Health and the Minister for Mental Health and Ageing announced the grants on 6 March 2012. ANPHA included details of the grants on its website on the same day.
Conflict of interest	Two grant assessment meetings (October and December) were held in 2011 at which specific conflicts of interest were verified from notifications provided to the Secretariat prior to the meetings. Members

Step	ANAO comment
	with conflicts, unless judged as having a perceived conflict of interest, were excluded from both discussion and decisions for the applications for which they had a conflict. ANPHA advised that an independent probity advisor attended both these meetings and reported no probity issues with the process.

Source: ANAO analysis of ANPHA records.

Funding approval of the research grants

5.9 FMA Regulation 8 provides that a person must not enter into an arrangement, such as a grant funding agreement, unless a spending proposal has been approved under FMA Regulation 9. FMA Regulation 9 provides that an approver (that is, a person, including a minister, who may approve proposals to spend public money) must not approve a spending proposal unless the approver is satisfied, after making reasonable inquiries, that giving effect to the spending proposal would be a 'proper use' of Commonwealth resources. Proper use is defined in section 44 of the FMA Act as 'efficient, effective, economical and ethical use that is not inconsistent with the policies of the Commonwealth'.[128]

5.10 Finance has advised agencies that:

> Under Regulation 9, approvers must take reasonable steps to satisfy themselves that the CPG [*Commonwealth Procurement Guidelines*, now the *Commonwealth Procurement Rules*] and CGG requirements have been complied with when assessing whether a spending proposal is in accordance with the policies of the Commonwealth.

[128] While recent amendments to the FMA Act, which came into effect on 1 March 2011, added 'economical' to the definition of proper use, the Department of Finance and Deregulation has advised that the concepts of efficient and effective already encompassed the concept of economical, which was added to emphasise the requirement to avoid waste and increase the focus on the level of resources that the Commonwealth applied to achieve outcomes. (See Finance Circular No. 2011/01 *Commitments to spend public money (FMA Regulations 7 to 12)*, available at <http://www.finance.gov.au/publications/finance-circulars/2011/docs/Finance-Circular-2011-01-FMA-Regulations-7-12.pdf> [accessed 16 August 2012]).

And:

> An approver, in relation to a spending proposal, including a grant, is defined in Regulation 3 to include a Minister. All approvers must comply with the Regulations. The CGGs contain a mandatory requirement that agencies must take appropriate and timely steps to advise a Minister of the requirements of the CGGs where the Minister undertakes the role of an approver in grants administration.[129]

5.11 The Grant Guidelines for the 2011–12 round of research grants specified that the Minister for Health and Ageing would make the decision on which applications would be funded.[130] As noted in Table 5.3, ANPHA provided advice to the Minister on 12 January 2012, seeking her 'approval for funding of the 13 recommended research projects under the ANPHA Preventive Health Research Grants Program'. As recommended, the Minister approved the grants, including the amount of each grant, on 21 January 2012. In doing so, the Minister provided the substantive FMA Regulation 9 approval for the grants.

5.12 The CGGs provide that:

> Agencies are responsible for advising Ministers on the requirements of the CGGs, and *must* take appropriate and timely steps to do so where a Minister exercises the role of financial approver in grants administration.[131]

5.13 The CGGs also provide that:

> The Australian Government has agreed that where a Minister exercises the role of a financial approver relating to a grant, they will not approve the grant without first receiving advice on the merits of the proposed grant.[132]

5.14 While the Minister received advice on the merits of the grants[133], and was advised that ANPHA had complied with the CGGs in assessing and selecting the grants, ANPHA did not advise her, at the time of approval in January 2012, that she was undertaking the role of an approver under FMA

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129 ibid, pp. 38–39.

130 ANPHA, *Preventive Health Research Grants Program: 2011–12 Funding Round—Grant Guidelines*, p. 1.

131 Department of Finance and Deregulation, *Commonwealth Grant Guidelines*, Financial Management Guidance No. 23, July 2009, paragraph 3.23, p. 11.

132 ibid., p. 10.

133 ANPHA provided details of the assessment process and of each recommended grant.

Regulation 9 and of the obligations applying to her as an approver, as required by the CGGs.

5.15 ANPHA had originally anticipated that the recipients of the Research Grants would be engaged by way of a funding agreement with the NHMRC. This approach was subsequently amended and the funding arrangements were then formalised by way of an agreement between ANPHA and the approved recipients. As the Goods and Services Tax (GST) status of each approved organisation was unknown at the time of approval, the request for approval of funding to the Minister did not identify the GST status of the grants. After the Minister approved the grants, ANPHA confirmed through legal advice from the Australian Government Solicitor that the amounts approved by the Minister needed to be amended to include GST. To provide FMA Regulation 9 approval for the revised cost of the grants, including GST, the CEO of ANPHA was advised on 17 April 2012 to approve the inclusion of GST in the funding agreements and to approve, under FMA Regulation 9, a revised overall expenditure of $4.23 million for the research grants. The CEO signed off on the advice on the same day.[134] While the CEO had authority to approve the variation, it would have been prudent for ANPHA to contemporaneously advise the Minister of the need for the variation and new approval, as the research grant guidelines informed applicants that the Minister would be the funding approver.

5.16 These matters were raised by the ANAO in the course of the audit. In a subsequent minute to the Minister of 26 October 2012, ANPHA advised of the CEO's approval of the variation, and sought the Minister's endorsement of that approval. This advice contained some minor errors, indicating that there is scope for ANPHA to improve quality control over its briefing material. In the course of the audit, ANPHA also advised that relevant templates had been updated to include a paragraph that informs the Minister, and other approvers, that they are undertaking the role of an approver under FMA Regulation 9 and of the obligations applying as an approver, as required by the CGGs.

[134] While the CEO signed off the minute containing the advice, she did not indicate explicitly whether the recommendations had been approved or not approved, although the clear implication was that, in doing so, she had approved the recommendations.

5.17 More broadly, ANPHA indicated that it is reviewing the grants process, in consultation with the NHMRC, so that the lessons learned from the first round of grants can be applied in future rounds and to satisfy itself that the most efficient and effective process is being adopted. Since January 2012, ANPHA has acquired dedicated in-house grants expertise to review and quality assure all grant documentation and ensure compliance.

Healthy Communities initiative

5.18 Under the Healthy Communities initiative, $71.8 million is being provided over five years from 2009–10 to support LGAs in delivering effective community-based physical activity and healthy eating programs, as well as developing a range of local policies that support healthy lifestyle behaviours. The initiative aims to:

> help reduce the prevalence of overweight and obesity within the target populations of participating communities by maximising the number of at-risk individuals engaged in accredited physical activity and dietary education programs.[135]

5.19 The 'target populations' are defined as adults who are predominantly not in the paid workforce, with preference given to disadvantaged individuals. The Healthy Communities initiative complements the other two Agreement initiatives that target specific populations (the Healthy Children and Healthy Workforce initiatives) so that collectively the three initiatives cover the Australian population.

5.20 Table 5.4 shows the key elements of the Healthy Communities initiative.

[135] Department of Health and Ageing, *COAG Healthy Communities Initiative, National Program Grants June 2010–June 2013: Program Guidelines 2009*, p. 3.

Table 5.4

Healthy Communities initiative—key elements

Local Government Area (LGA) grants ($61.5 million)
Grants to 92 LGAs to deliver community-based healthy lifestyle programs (including physical activity, healthy eating and healthy weight programs) in their local areas.
National Program grants ($6.5 million)
Grants to six not-for-profit organisations to help extend their healthy lifestyle programs nationally, including to LGA grant recipients wishing to use them.
Quality framework, registration and information portal ($2.5 million)
A quality framework with key standards to help ensure that healthy lifestyle programs operating under the initiative and the qualifications of the people who deliver them are of an appropriate standard and quality. A registration body to assess programs and providers against the quality framework. An information portal—the Healthy Living Network—that allows for online lodgement of applications for registration and lists registered programs and providers.
Evaluation ($1.4 million)
An evaluation of all components of the initiative (to be finalised by September 2013).

Source: DoHA.

5.21 The then Minister for Health and Ageing approved the implementation arrangements for the initiative on 1 June 2009.

Healthy Communities initiative grants

Grants to LGAs

5.22 Ninety-two grants have been provided to LGAs over three phases under the Healthy Communities initiative, as outlined in Table 5.5.[136]

[136] It was originally anticipated that there would be four rounds of grants, but, following consultations with stakeholders, it was determined that the amount of grants funding that would be available with four rounds would be insufficient to establish and deliver a sustainable program in areas of disadvantage, the target areas of the grants. As a result, the Minister for Health and Ageing agreed to increase individual grant amounts and conduct three rounds of grants.

Table 5.5

Grants to LGAs under the Healthy Communities initiative

Phase	LGAs funded
1	Phase 1 was a Pilot Phase. Grants (of $410 130, GST exclusive, per grant) to 12 LGAs to undertake pilot programs between April/May 2010 and June 2011. These grants have since been extended to June 2013 ($566 042, GST exclusive, per grant), based on satisfactory assessments of their performance during the pilot period.
2	Grants to 33 LGAs (of $733 607, GST exclusive, per grant), from June 2011 to June 2014.
3	Grants to 47 LGAs (of $566 042, GST exclusive, per grant), from November 2011 to June 2014.

Note: Funding of Phase 2 and 3 LGAs was originally intended to cover the period to June 2013. This has been extended to June 2014 to give LGAs in these phases more time to deliver programs and embed them into the community. The extended timeframe does not provide additional funding, but involves a movement of $11.1 million from 2012–13 into 2013–14.

Source: DoHA website, Healthy Communities Initiative web page, <http://www.health.gov.au/internet/healthyactive/publishing.nsf/Content/healthy-communities> [accessed 1 August 2012].

5.23 The steps taken by DoHA to process the applications and to ensure consistency with the CGGs (as outlined in Table 5.2) and with the initiative objectives are outlined at Table 5.6.

Table 5.6

Administration of grants to LGAs under the Healthy Communities initiative

Phase 1	Phase 2	Phase 3
Development of grant guidelines		
The then Minister for Health and Ageing approved the guidelines and information pack for the Phase 1 pilot phase on 6 October 2009 for submission to the ERC for final approval.	The then Minister for Health and Ageing approved the guidelines for Phases 2 and 3 on 18 October 2010. The Minister for Finance and Deregulation wrote to the then Minister for Health and Ageing on 4 November 2010 raising no objection to the release of the program guidelines for Phases 2 and 3. The guidelines were not required to be submitted to the ERC following changes in September 2010 to the requirement for all grant guidelines to be considered by the ERC.	
	The then Minister for Health and Ageing approved the Phase 2 funding round on 18 October 2010.	The Minister for Health and Ageing approved the Phase 3 funding round on 29 June 2011.
Inviting applications		
42 LGAs were invited to apply for the Phase 1 pilot phase on	Applications opened on 20 November 2010 and closed	Applications opened on 6 July 2011 and closed on

Phase 1	Phase 2	Phase 3
the basis of advice from states and territories. States and territories used their local knowledge of the capacity of LGAs and information provided by DoHA in making their nominations of pilot sites.	on 4 February 2011.	19 August 2011.
Appraisal and shortlisting of applications		
30 applications were received for the Pilot Phase. The applications were considered by an assessment panel using application selection criteria listed in the grant guidelines for this phase of the initiative and using weightings approved by DoHA for each of the criteria and sub-criteria. Twelve applications were recommended for funding as part of the pilot phase. These included a mix of metropolitan, regional and rural LGAs. Three LGAs had a specific focus on targeting Indigenous populations and one targeted culturally and linguistically diverse populations. In accordance with the guidelines, the 12 grants were distributed proportionally across the jurisdictions.	110 Phase 2 applications were received and were reviewed by three departmental panels against the guidelines and a scoring matrix to help ensure consistency. 33 applications were recommended for funding in Phase 2. 44 applications were considered suitable but not recommended for funding in this Phase and 33 applications were considered unsuitable. In accordance with the guidelines, grants were distributed proportionally across the jurisdictions. Of the 33 LGAs funded: • 73 per cent had an emphasis on regional and remote areas; • only seven had a SEIFA (Socio-Economic Indices for Areas) rating above the Australian average; and • nearly 80 per cent had combined obesity and overweight rates above the Australian average.	122 Phase 3 applications were received and were reviewed by five departmental panels against the guidelines and a scoring matrix to help ensure consistency. 47 applications were recommended for funding in Phase 3. In accordance with the guidelines, grants were distributed proportionally across the jurisdictions. Of the 47 LGAs funded: • 60 per cent had an emphasis on regional and remote areas; • only 13 had a SEIFA rating above the Australian average; and • nearly 77 per cent had combined obesity and overweight rates above the Australian average.
The grant guidelines for Phase 1 differed from those used for Phases 2 and 3. The latter were considerably shorter than the guidelines for Phase 1. The ANAO's *Better Practice Guide on Grants Administration* (pp. 65–66) notes that it may be appropriate to assign individual weightings to individual assessment criteria to target available funding at projects that exhibit particular characteristics. It also notes that the transparency, consistency and defensibility of the assessment process is supported by grant program guidelines making clear the extent, if any, to which the nominated assessment criteria will be more weighted (or favoured) in determining an application's overall assessment. DoHA weighted the assessment criteria for each phase of the project (although the guidelines did not indicate that weightings would be applied in assessing how well each application met the assessment criteria and, in the interest of transparency, could be included in the future). In the ANAO's view, there was the potential for some misunderstanding by applicants about the		

Phase 1	Phase 2	Phase 3
application of the assessment criteria in Phase 1 by the way in which they were presented in the application guidelines. Under the heading 'Assessment Criteria', the Phase 1 guidelines stated that, in the assessment of applications, 'consideration would be given equally to a number of criteria'. Later in the guidelines there was a detailed statement of the assessment criteria, which did not map to the earlier criteria. The wording of the earlier statement could also have been taken to imply that there would be no priority weighting of the assessment criteria.		
Approval of grants to LGAs		
In February 2010 DoHA endorsed the recommendations of the selection panel and agreed to the commencement of 'without prejudice' negotiations with the 12 recommended grant recipients, subject to the Minister endorsing the outcome of the selection process. In March 2010, the then Minister for Health and Ageing endorsed the preferred 12 applicants for funding in the Pilot Phase to June 2011. DoHA arranged for a performance review of the 12 pilot sites to be carried out. On the basis of this review, in May 2011 the Minister approved the extension phase of the project and varying the funding agreements with 11 of the pilot sites to June 2013. In June 2011, DoHA approved a variation of the 12th site's agreement and extension to June.	In May 2011, DoHA approved the 33 recommended applications in principle and commencement of 'without prejudice' negotiations with the recommended applicants. The then Minister for Health and Ageing noted advice on the results of the assessments, prior to the commencement of the 'without prejudice' funding agreement negotiations. FMA Regulation 9 approval was obtained once these negotiations had been completed.	In November 2011, DoHA approved the 47 recommended applications and the then Minister for Health and Ageing noted advice on the results of the assessments, prior to the commencement of funding agreement negotiations. Regulation 9 approval was obtained once 'without prejudice' funding negotiations had been completed.
FMA Regulation 9 and 10 approvals		
FMA Regulation 10 approvals to the pilot phase and to the extension of the pilot phase were obtained. FMA Regulation 9 approvals were also obtained.	FMA Regulation 9 and 10 approvals were obtained.	FMA Regulation 9 and 10 approvals were obtained.
FMA Regulation 9 and 10 approvals were provided by the departmental delegate.		
Announcement of grants		
The then Minister for Health and Ageing announced the grants for the pilot phase on 29 March 2010, but did not announce the extension of the	The then Minister for Health and Ageing announced the 33 Phase 2 grants on 8 June 2011.	The then Minister for Health and Ageing and the Member for McEwen announced the grants on 6 December 2011.

Phase 1	Phase 2	Phase 3
Phase 1 grants.		
Reporting on the execution of funding agreements		
The CGGs provide that an agency *must* publish, on its website, information on its individual grants no later than seven working days after the funding agreement for the grant takes effect. Nine grants were included on DoHA's website outside this timeframe. All of the executed grants were included on DoHA's website within 18 days		

Source: ANAO analysis.

5.24 LGAs were required to prepare detailed implementation plans, using a standard template prepared by DoHA. Evaluation Guides for LGAs in each of the three phases of the LGA grants component of the Healthy Communities initiative have also been prepared. Most performance reports will only commence in respect of the 2011–12 financial year.[137]

National program grants

5.25 LGA grant recipients are expected to incorporate national grant lifestyle programs in their service offerings. These national programs are being provided by six not-for-profit organisations, which were selected to expand their healthy lifestyle programs across Australia.[138] DoHA has advised that all LGAs are implementing at least one national program in their service offerings.

Quality framework

5.26 DoHA has established a quality framework to support the Healthy Communities initiative and to provide assurance on the quality of services being provided under the Healthy Communities initiative, including by the national providers of healthy lifestyle programs. This framework has three components, as shown in Table 5.7.

[137] While LGAs are required to submit six-monthly reports, most performance information only needs to be submitted on an annual basis.

[138] These were: the Australian Diabetes Council; Cycling Australia (with the Amy Gillett Foundation); Fitness Australia (with Baker IDI Heart and Diabetes Institute); National Heart Foundation of Australia; National Heart Foundation of Australia—NSW Division; and Sydney South-West GP Link.

Table 5.7

Healthy Communities Initiative Quality Framework

Component	Description/Purpose	Object/Target
Service provider registration	A set of quality standards and performance criteria organised into eight domains and a self assessment process developed for providers of healthy lifestyle programs to help ensure a provider's services are of a sufficient quality.	Must be completed in order to become a registered provider under the Healthy Communities Initiative Quality Framework.
Program registration	A set of criteria to assess the quality of LGA program guidelines.	Must be completed in order to register a program under the Healthy Communities Initiative Quality Framework and be listed on the information portal—the Healthy Living Network.
Principles (for LGAs)	A set of capacity building principles to be used by LGAs to assist in developing, implementing and sustaining effective local approaches to promoting and supporting healthy communities.	Is provided as a guide only and is not assessed under the Healthy Communities Initiative Quality Framework.

Source: DoHA, *Healthy Communities Initiative Quality Framework*, p. 5.

5.27 Registered providers and programs are expected to be reassessed every two years or sooner if significant amendments to the program occur (including change to program scope, qualifications required and major changes to approach or content).

5.28 An external provider was selected as the registration body after a public tender, and was required to manage the information portal. However, the implementation of the portal by the provider, which was expected to be available to assist with the registration of LGA providers and their programs before they commenced operation, did not occur until March 2012, when the Healthy Communities initiative was well underway. DoHA has advised the ANAO that no LGAs had completed registration as a service provider or program. However, all six national program grant recipients had completed the service provider registration.

5.29 While it is not mandatory for LGAs to register with the Healthy Living Network, DoHA advised that they are encouraged to do so and they are able to obtain registrations without charge while it is funding the network. However, the late implementation of the network, after programs had commenced, has reduced the incentive for LGAs to obtain service provider and program registrations. Only 10 licensee and 22 program registrations were

in progress as at 17 July 2012. The low number of registration applications as a result of the late implementation of the network means that the assurance that the network was intended to provide is not available. In October 2012 DoHA advised that it is working closely with the external provider and LGAs on the promotion of the Healthy Living Network and encouraging LGAs to register.

Evaluation

5.30 DoHA has developed a guide to assist both LGA and National Program grant recipients to evaluate their own programs and to contribute to the national evaluation of the Healthy Communities initiative. The evaluation is expected to be completed, when the initiative concludes on 30 June 2014.

5.31 DoHA commissioned an evaluation of the implementation of the pilot sites in Phase 1.[139] This evaluation helped to inform Phases 2 and 3. For example, the evaluation recommended, and the department agreed, that national program grant recipients be provided with a list of successful Phase 2 and Phase 3 LGAs that had expressed an intention to incorporate national program grant services in their local programs. Similarly, the evaluation recommended a number of measures to encourage shared learning between LGAs, and DoHA has generally adopted these. While it was too early to collect meaningful evidence on the benefits of participation, early indications were that participants had benefitted in terms of their increased awareness of risk factors associated with overweight and obesity, improved skills to address these risk factors and an intention to adopt a healthier lifestyle.[140]

5.32 The first of two interim evaluation reports was completed in March 2012 and the final evaluation is planned for completion in September 2013. While the first interim evaluation was conducted at a relatively early stage in the program, the evaluation reported favourably on progress to March 2012. It found that participants were not only engaging in program activities, but in some cases beginning to derive some benefit from their participation in these activities, including increased awareness of risk factors, increased knowledge of healthy lifestyles, skills to support healthier lifestyles and an intention to transfer what they had learnt into their lives. There were also signs that some

[139] KPMG, *Evaluation of the Healthy Communities Initiative—Pilot Implementation Report*, June 2011, and *Evaluation of the Healthy Communities Initiative—Pilot Implementation Report—Supplementary Report*, July 2011.

[140] ibid, p. iv.

participants had increased their physical activity or healthy eating behaviours.[141]

Australian Health Survey

5.33 The Agreement states that, as part of delivering 'soft infrastructure', the Commonwealth has responsibility for the 'expansion of the National Nutrition and Physical Activity Survey to include individuals of all ages, Indigenous Australians and bio-medical measures'.[142] The Australian Health Survey is being undertaken between 2011 and 2014 using resources from the Australian Bureau of Statistics (ABS), DoHA and the National Heart Foundation of Australia so as to provide a comprehensive and more up-to-date picture of the health of Australians. The data is to assist clinicians, health professionals, researchers, policy makers and government to develop and provide the right types of services for Australians.

5.34 Cardiovascular disease, Type 2 diabetes and chronic kidney disease together account for almost two-thirds of all deaths and approximately one quarter of the burden of disease in Australia.[143] These diseases share many modifiable common risk factors, including smoking, poor diet, obesity and physical inactivity, and so are preventable. Reducing the incidence of these diseases is therefore a high priority. To date, estimates of the prevalence of cardiovascular disease, Type 2 diabetes and chronic kidney disease have relied heavily on self-reported information. However, as this information does not include data on undiagnosed cases of disease and may include reporting bias, it is likely to underestimate the true prevalence of these diseases. To obtain more accurate estimates of the prevalence of these diseases, the Australian Government has provided funding through the Agreement to include a biomedical component in the Australian Health Survey. The funding also enables the Australian Health Survey to cover children from two years and over and Aboriginal and Torres Strait Islander communities.

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[141] KPMG, *Department of Health and Ageing: Evaluation of the Healthy Communities Initiative—Interim Report One*, March 2012, p.vii.

[142] COAG, National Partnership Agreement on Preventive Health, December 2008, p. 7.

[143] Australian Institute of Health and Welfare, *Prevention of cardiovascular disease, diabetes and chronic kidney disease: targeting risk factors*, 2009, Cat. no. PHE 118. Canberra: AIHW, p. vii.

5.35 The ABS advised the ANAO in July 2012 that the survey is proceeding broadly in line with the expected timeframes for its completion, with results being released progressively. The first results were released on 29 October 2012. These results indicated, among other things, that:

- rates of daily smoking among those aged 18 years and over have continued to drop to 16.3 per cent in 2011–12, from 18.9 per cent in 2007–08 and 22.4 per cent in 2001;
- the proportion of people aged 18 years and over who consumed more than two standard drinks per day on average, exceeding the National Health and Medical Research Council lifetime risk guidelines, decreased to 19.5 per cent in 2011–12 from 20.9 per cent in 2007–08; and
- the prevalence of overweight and obesity in adults aged 18 years and over has continued to rise to 63.4 per cent in 2011–12 from 61.2 per cent in 2007–08 and 56.3 per cent in 1995.[144]

Workforce audit and strategy

5.36 The Agreement provides funding of $500 000 for the Commonwealth to carry out an audit of the existing preventive health workforce, which would then inform the development of a preventive workforce strategy. The audit is designed to provide a framework by which the preventive health workforce can develop and maintain the capacity to cope with a health system increasingly focused on preventive health measures. The preventive workforce audit was initiated and completed by DoHA, pending the establishment of ANPHA. However, ANPHA is now responsible for developing the preventive health workforce strategy.

Preventive health workforce audit

5.37 The preventive health workforce audit was conducted by consultants engaged by DoHA and was released publicly in June 2012.[145] It was confined to the expected workforce needs of the Agreement only.

[144] Australian Bureau of Statistics, *Australian Health Survey: First Results 2011–12*, Catalogue No. 4364.0.55.001, 29 October 2012.

[145] Human Capital Alliance, *Audit of the Preventive Health Workforce in Australia, Final Report of Project Findings*, 2012.

5.38 The audit defined the preventive health workforce in terms of 'direct' and 'indirect' workers, and their sub-classifications. Direct workers included those associated with policy, research and practice, while indirect workers included those who may not have an obvious link to prevention as well as workers such as carers, teachers, social workers, youth workers and workers from other professions involved in health promotion, whose involvement can have a profound effect on health outcomes.

5.39 The workforce audit found that the preventive health workforce is expanding quickly, is flexible enough to adapt to the immediate demands of the Agreement initiatives and that one of the key factors limiting the program's implementation is distance from metropolitan areas.

5.40 Although the workforce audit draft report was completed in a timely way and within the overall budget for the workforce audit and strategy, there was a delay in the release of the final audit report, as it took some time to be cleared for release by state and territory jurisdictions, which initially were concerned that their views had not been adequately reflected in the report.

Preventive Health Workforce Strategy

5.41 While DoHA had responsibility for management of the workforce audit, ANPHA has responsibility for developing the preventive health workforce strategy. As a result, $254 000 in funds remaining for this initiative, after completion of the preventive health workforce audit, were transferred from DoHA to ANPHA for the development of the strategy.

5.42 ANPHA states in its Key Result Area 5.1 that the preventive health strategy will encompass program design and delivery, research and evaluation of competency needs. ANPHA is using the conclusions of the workforce audit in part to inform the strategy development and plans to work closely with Health Workforce Australia (HWA) to undertake this task.[146] ANPHA and HWA have agreed on their respective roles in the development of the strategy. ANPHA will have overall responsibility for management of the project, including its development, implementation and outcomes, while HWA will

[146] HWA is a Commonwealth authority that was established in response to the 2008 COAG National Partnership Agreement for Hospital and Health Workforce Reform. The aim of HWA is to meet the future challenges of providing a health workforce that responds to the needs of the Australian community.

assist ANPHA, and provide expert input on workforce issues for the project, including in relation to modelling the preventive health workforce.

5.43 Consistent with the findings of the workforce audit, ANPHA considers that a relatively broad approach, including both direct and indirect workers, needs to be taken in developing the preventive health workforce strategy. This approach is reflected in the draft strategy documents available at the time of this audit. Issues related to workforce training, capacities, future needs and retention are expected to be addressed in the strategy.

5.44 ANPHA's 2012–13 operational plan indicates that a discussion paper would be released for consultation in September 2012. However, a draft discussion paper was presented to the Healthies Steering Committee in early November 2012, and was being amended in line with suggestions made at the meeting.[147] The operational plan also identified that a draft strategy is planned to be released for consultation in June 2013.[148] The final strategy is expected to be submitted to the Standing Council on Health in the second half of 2013, and implementation of the strategy some time after that. Accordingly, implementation of the strategy is unlikely to occur before 2014–15, limiting the opportunity to achieve significant outcomes during the term of the Agreement. The ANAO therefore suggests that consideration be given to assigning a higher priority to completion and implementation of the strategy.

National Eating Disorders Collaboration

5.45 In October 2008, the Government allocated $500 000 for a National Eating Disorders Collaboration (the Collaboration). Under the Agreement, COAG authorised an extension of the Collaboration, with $3.0 million allocated over four years (from 2009 to 2013) to 'provide a national focal point for prevention, early intervention and best practice treatment strategies for disordered eating'.[149]

[147] The development of resources to support the preventive health workforce will be guided and endorsed by the Healthies Steering Committee.

[148] ANPHA *Operational Plan 2012–2013*, KRA 5.1, p. 10.

[149] National Partnership Agreement on Preventive Health Implementation Working Group, *National Partnership Agreement on Preventive Health—National Implementation Plan 2009–2015*, June 2009, p. 133 and COAG, *National Partnership Agreement on Preventive Health*, December 2008, pp. 5 and 7.

5.46 Specific medium to long-term outcomes under the Agreement that relate to the Collaboration are designed to lead to: an increase in the proportion of children and adults at healthy body weight by three percentage points within 10 years; and an increase in the proportion of children and adults meeting national guidelines for healthy eating and physical activity by 15 per cent within six years.[150]

5.47 In June 2010 DoHA entered into a funding agreement with the Butterfly Foundation to establish and deliver the Collaboration.[151] The ANAO's analysis of the implementation of specific outputs aimed at meeting the medium and long-term outcomes for the Collaboration are identified in the National Implementation Plan for the Agreement, and are considered in Table 5.8.

Table 5.8

ANAO analysis of progress in implementing National Eating Disorders Collaboration outputs

Output	ANAO findings
An evidence-based framework Developing a national evidence-based framework for eating disorders, informed by analysis of existing resources, approaches and their evidence base and identifying further work that needs to be undertaken for a consistent, national approach to eating disorders.	An evidence-based framework *Eating Disorders—The Way Forward: An Australian National Framework* was published in March 2012. To further improve the strategy, DoHA has advised that a 'gap analysis' of the current framework is taking place and further consultations are taking place with stakeholders.
Collaboration of experts Building a collaboration of experts and key stakeholders in the field of eating disorders, including the delivery of national workshops to build inter-sectoral and interdisciplinary coordination and evidence sharing on eating disorders.	The Collaboration has brought together experts in the field of eating disorders. It has 362 members and engages with stakeholders that range from individuals, eating disorder professional groups, industry bodies and state and territory governments. Key activities included the development of a governance charter (completed in September 2010) and a work plan for 2011–12.
Communication strategy Developing and implementing a comprehensive national strategy to	The communications strategy, *Clarity in Complexity: Strategic Communication to Support the Prevention and Early Identification of Eating Disorders*, published in March 2012, is designed to provide an evidence-based

[150] COAG, *National Partnership Agreement on Preventive Health*, December 2008, p. 5.

[151] DoHA undertook a competitive tender process and an Invitation to Apply was published in *The Australian* newspaper on 19 December 2009. The acceptance of applications closed on 1 February 2010, with four applications received.

Output	ANAO findings
communicate appropriate evidence-based messages to schools, the media and health service providers.	approach for communicating with the public about eating disorders, engagement in prevention programs and encouragement of help seeking.
Evaluation and monitoring performance Conducting an evaluation of the project.	An evaluation plan has been finalised and the evaluation is expected to be completed by May 2013. The Butterfly Foundation is providing progress performance reports to DoHA, and these identify that evaluation activities are taking place, such as analysing risk management processes and reviewing feedback from stakeholder consultations. DoHA also advised that it monitors the work of the National Eating Disorders Collaboration through: • the receipt of performance reports, as required by the Funding Agreement with the Butterfly Foundation; • fortnightly face-to-face meetings with the Chief Executive Officer of the Butterfly Foundation; and • bi-monthly NEDC Steering Committee meetings which include discussions on the work to date, as well as the future work of the National Eating Disorders Collaboration.

Source: ANAO analysis.

5.48 The Butterfly Foundation advised the ANAO that it is very satisfied with the way that DoHA has managed its contracted deliverables. Furthermore, it advised that it considers that the network of members that has been established is helping to develop worthwhile links between different stakeholders in the National Eating Disorders Collaboration. A key issue for DoHA will be to assess how the current progress with the Collaboration can be translated into reduced eating disorders in the community.

5.49 While there was some slippage in finalising certain key guidance documents, they have now been published.[152] DoHA advised that this slippage was due to a delay in the establishment of the Mental Health Standing Committee, but that the project is now progressing in accordance within the set timeframe.

Ian McPhee
Auditor-General

Canberra ACT
5 December 2012

[152] The communication strategy was published in March 2012, instead of June 2010 as initially scheduled, the framework for eating disorders was published in March 2012, instead of March 2010 and the evaluation plan was finalised in January 2011, instead of March 2010.

Appendices

Appendix 1: Agencies' Responses

Australian National
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Dr Tom Ioannou
Group Executive Director
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Australian National Audit Office
19 National Circuit
BARTON ACT 2601

Proposed Audit Report on the Administration of Commonwealth Responsibilities under the National Partnership Agreement on Preventive Health (NPAPH)

Dear Dr Ioannou

I refer to your correspondence of 24 October providing a copy of the above audit report in accordance with section 19 of the *Auditor General Act 1997*. I also refer to subsequent discussions between Mr Andrew Morris of your office and Ms Roz Lucas of ANPHA about the report.

I understand that the final report will contain one recommendation about the administrative process for the *Swap It, Don't Stop It* campaign. I also understand that this recommendation will reflect that future campaign compliance statements should include a document that clearly relates evidence to the factual statements appearing in campaign material.

ANPHA agrees to the recommendation on this basis.

This is the first performance audit of the agency since its establishment on 1 January 2011. Whilst the focus of the audit was the NPAPH, the agency's establishment, its role and activities since inception, and the way in which the Department of Health and Ageing and the agency work together to achieve the policy objectives of the NPAPH were also the subject of the audit.

The ANAO's examination of the governance framework and the program implementation arrangements will contribute to the agency's compliance framework and continued sound governance.

I would like to pass on my appreciation to the audit team for the collaborative approach taken to the audit process. The audit has been a useful experience for the agency and the report will provide a helpful basis for continuous improvement in the agency's work.

Yours sincerely,

Louise Sylvan
CEO ANPHA
19 November 2012

www.anpha.gov.au

CD
22 NOV 2012
9.30

Australian Government

Department of Health and Ageing

SECRETARY

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Australian National Audit Office
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CANBERRA, ACT 2601

Dear Dr Ioannou

PROPOSED AUDIT REPORT: ADMINISTRATION OF COMMONWEALTH RESPONSIBILITIES UNDER THE NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

Thank you for providing the opportunity for the Department to comment on the ANAO's proposed report on the above audit, noting that only the first of the three recommendations are directed to the Department, while the remaining two fall within the remit of the Australian National Preventive Health Agency.

I understand there were discussions held between the Department and the ANAO team on 28 September 2012 and again on 9 November resulting in a number of changes to the Issues Papers and an earlier version of the proposed report.

The Department agrees to Recommendation No.1 and adds that processes are currently underway to address this through established governance arrangements under the Agreement. Consultation with relevant technical experts and with the states and territories, for resolving data issues to measure performance for reward payments as highlighted in this recommendation, are currently being progressed by the Department.

Yours sincerely

Jane Halton PSM
Secretary

20 November 2012

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Index

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Series Titles

ANAO Audit Report No.1 2012–13
Administration of the Renewable Energy Demonstration Program
Department of Resources, Energy and Tourism

ANAO Audit Report No.2 2012–13
Administration of the Regional Backbone Blackspots Program
Department of Broadband, Communications and the Digital Economy

ANAO Audit Report No.3 2012–13
The Design and Conduct of the First Application Round for the Regional Development Australia Fund
Department of Regional Australia, Local Government, Arts and Sport

ANAO Audit Report No.4 2012–13
Confidentiality in Government Contracts: Senate Order for Departmental and Agency Contracts (Calendar Year 2011 Compliance)
Across Agencies

ANAO Audit Report No.5 2012–13
Management of Australia's Air Combat Capability—F/A-18 Hornet and Super Hornet Fleet Upgrades and Sustainment
Department of Defence
Defence Materiel Organisation

ANAO Audit Report No.6 2012–13
Management of Australia's Air Combat Capability—F-35A Joint Strike Fighter Acquisition
Department of Defence
Defence Materiel Organisation

ANAO Audit Report No.7 2012–13
Improving Access to Child Care—the Community Support Program
Department of Education, Employment and Workplace Relations

ANAO Audit Report No.8 2012–13
Australian Government Coordination Arrangements for Indigenous Programs
Department of Families, Housing, Community Services and Indigenous Affairs

ANAO Audit Report No.9 2012–13
Delivery of Bereavement and Family Support Services through the Defence Community Organisation
Department of Defence
Department of Veterans' Affairs

ANAO Audit Report No.10 2012–13
Managing Aged Care Complaints
Department of Health and Ageing

ANAO Audit Report No.11 2012–13
Establishment, Implementation and Administration of the Quarantined Heritage Component of the Local Jobs Stream of the Jobs Fund
Department of Sustainability, Environment, Water, Population and Communities

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